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: AL Harbor Chase of Wilmington

DATE SURVEY COMPLETED: April 19, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced Annual and Complaint survey was conducted at this facility beginning April 15, 2024, and ending April 19, 2024. The facility census on the entrance day of the survey was 105 (one hundred five) residents. The survey sample was composed of twenty-seven (27) 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; Contract - A legally binding written agreement between the facility and the resident which enumerates all charges for services, materials, and equipment, as well as non-financial obligations of both parties, as specified in the State regulations; CP – Care Partner; DLE – Director of Life Enrichment; DMC – Director of Memory Care; DOH – Director of Hospitality; DOM – Director of Maintenance; DOS – Director of Sales; DRC - Director of Resident Care; ED – Executive Director; EMR – Electronic Medical Record;	Date certain / completion: June 18, 2024

Provider's Signature [signature] Title Exective Dir. Date 5/22/24

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	ER - Emergency Room; LPN -Licensed Practical Nurse; MA – Medication Assistant; MAR – Medication Administration Record; MC – Memory Care; POA- Power of Attorney; RN – Registered Nurse; SA – Service Agreement; SAM – Self Administration of Medications; Steri-strip – Surgical tape strips which can be used to close small wounds; TID – Three times per day; UAI – Uniform Assessment Instrument.	
3225.5.0 3225.5.2	**General Requirements** **All records maintained by the assisted living facility shall at all times be open to inspection and copying by the authorized representatives of the Department, as well as other agencies as required by state and federal laws and regulations. Such records shall be made available in accordance with 16 Del.C. Ch. 11, Subchapter I., Licensing by the State.** This requirement was not met as evidenced by: The facility was out of compliance with this requirement at the start of, during, and at com-	1. No individual was cited related to this practice. Residents were not affected by this practice. 2. No residents have the potential to be affected by this practice. 3. The community recently had an update to the EMR and user rights for the electronic resident records. The community had to have the home office grant access to the medical records for the survey team. The community will have the systems passwords on hand for access to the appropriate resident records in Yardi. IF the state survey computers are not able to download the e-mars system, the community will always have on hand a sperate computer available for the states use in a private setting. The DRC, ED,

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	pletion of the on-site survey. As a result, the authorized representatives of the Department never had the required access to records. Findings include: During the survey, the Surveyors were denied access to the EMR for 1.6 days. Once electronic access was obtained, the Surveyors were limited to view only certain areas of the records. The Surveyors were required to request certain aspects of the resident records in which E2 (DRC) did print the information requested and forwarded to the Surveyors. The electronic MAR was not accessible unless the Surveyor went to the nurses' station to view on their computers while the facility staff were in attendance and were supervising what was being reviewed. This was not resolved by the survey end. 4/19/24 - Findings were reviewed with E1 (ED), E2 (DRC) and O1 (Ombudsman) at the exit conference, beginning at approximately 2:30 PM.	and BOM will be in-serviced by the home office IT team on how to sign in to the electronic resident files. The passwords and computer functionality will be tested monthly by the DRC or designee to ensure that all files will be easily accessed by the State's survey team. Policies and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The DRC or designee will report findings related to functionality of the spare computer during the quarterly QAPI meeting. The QAPI committee will review findings during the quarterly QAPI meeting then make recommendations. The frequency of the audits adjusted according to outcomes. Date certain / completion: June 18, 2024
3225.5.12	**An assisted living facility that provides direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education programs. The mandatory training must include communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to be taken with those persons. This paragraph shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code.**	1. No resident was affected by this practice. 2. All residents have the potential to be affected by this practice. The Relias support team was notified and corrected the computer glitch. E25 completed the electronic Relias training related to state mandated annual training for dementia, abuse, emergency preparedness, the following day after the surveyor noted the noncompliance for 2023. 3. The BOM audited the Relias for completion for annual training compliance as mandated by State regulations 4/19/24 and sent out notices to employees to complete the mandated annual training for all staff requiring this training. Department heads have been given a list of staff that need the in-services. The BOM will audit Relias training records of mandatory

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	This requirement was not met as evidenced by: Based on employee training review and interviews, it was determined that for one (E25) out of seven employee trainings reviewed, the facility failed to provide dementia, abuse, and emergency preparedness training. In addition, a facility staff member admitted that the facility's chosen software created a false record that a training had been completed when, in fact, it had not. Findings include: 12/15/22 - E25 (RN) was hired at the facility and received the dementia, abuse, and emergency preparedness at that time. There was no evidence of training completed in the 2023 year. 4/18/24 – E4 (BOM) confirmed a software glitch in the training program for E25 at approximately 10:00 AM. 4/19/24 – Per interview with E1 (ED) at approximately 2:20 PM, E1 stated there was a glitch in the electronic training software the facility used. E1 stated that the training system indicated the training was completed for E25, but in actuality it was not. 4/19/24 - Findings were reviewed with E1 (ED), E2 (DRC) and O1 (Ombudsman) at the exit conference, beginning at approximately 2:30 PM.	annual training for employee completion and Relias accuracy x 3weeks then monthly x2 or when 100% compliance is achieved. Outcomes will be corrected when noted then provided to NHA to review at the quarterly QAPI committee meeting. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The DOM or designee will audit employee Relias records weekly x3 then monthly till employees records are in 100% in compliance. Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes. Date certain / completion: June 18, 2024
3225.8.0 3225.8.3	**Medication Management** **Medication stored by the assisted living facility shall be stored and controlled as follows:**	1. A new lock and key were purchased and installed in Cart 2 in March. Residents who we affected by this event had their medications replaced at the facility cost. Nothing can be done for those who missed medications due to the event. No residents were affected by the unlocked medication cart found at time of survey.

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: AL Harbor Chase of Wilmington

DATE SURVEY COMPLETED: April 19, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3225.8.3.1	**Medication shall be stored in a locked container, cabinet, or area that is only accessible to authorized personnel;**	2. Any resident who had narcotics in Cart 2 could have been affected by this situation and all residents could have been affected by the unlocked medication cart.
3225.8.3.2	**Medication that is not in locked storage shall not be left unattended and shall not be accessible to unauthorized personnel;** This requirement was not met as evidenced by: Based on record review and interviews, it was determined that the facility failed to store narcotics in a locked container that is only accessible to authorized personnel as evidenced by the facility authorizing the use of a master key to open the second-floor medication cart without adding a secondary lock after the cart's key was reported missing on or around February 21, 2024. Additionally, during observation medications were left unlocked and unattended. The facility failed to ensure that the narcotics were properly secured (locked) for 30 days allowing an unknown number of unauthorized persons to have access by using a master key. As a result, 42 narcotic medications were "missing" (unaccounted for) and multiple doses of prescribed narcotic medications were missed by residents. Findings include: Cross refer to 8.8.2 examples 1 and 3. 1. 2/21/24 4:46 PM – E2 (DRC) authored an email to the E30 (pharmacist) stating, "Subject: second floor narcotic key. Has been lost for a few days now. Could you please send us a new lock and key. (sic) Would pharmacy install it or would we?"	3.Nurses and med techs will in serviced on medication storage and keeping unattended carts locked by the DRC. A daily cart lock audit will be conducted by ED or designee for 30 days and then weekly x 4 until 100 % compliance is achieved. The facility will obtain a lock and key compatible with the current carts we have to have as back -up in case a situation of lost keys should occur again. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4.Findings will be reported during the QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes. Date certain / completion: June 18, 2024

Provider's Signature __________ Title __________ Date __________

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	2/21/24 6:09 PM – E30's (pharmacist) email response to E2 stated, "If you take a picture of the lock, there is a number, and I can order a replacement key." 2/23/24 1:07 PM – E2's email to E30 stated, "The lock number is 1M 185." The facility was not able to provide evidence that the second-floor medication cart key or lock was replaced or re-keyed. Without ascertaining the location of the lost keys or who was in possession of them, the facility failed to ensure that only authorized personnel had access to the second floor medication cart and narcotic box. This situation was in effect for a total of 30 days. 3/4/24 3:13 PM – E2's email to E30 stated, "This is the lock that we have lost the key for. We are using a master but would like a key to replace the one they lost. Thanks in advance." 3/17/24 approximately 9 AM – Forty-two (42) narcotic medications were reported "missing" from the second-floor medications cart. 3/19/24 10:06 AM – E2's email to E30 stated, "We had narcs go missing over the weekend. We are investigating that now, but it is from the cart that we lost the key to the narc box about two months ago. We have not gotten any replacement. At this point I would like the lock completely changed to a new lock with a new key." 3/22/24 – E9 (DOM) applied a refrigerator door lock to the second floor medication cart for additional security until the cart's lock could be changed.	

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: AL Harbor Chase of Wilmington

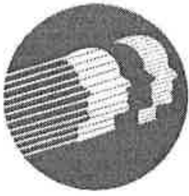
DATE SURVEY COMPLETED: April 19, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	3/24/24 – E9 ordered online a 2-pack refrigerator door lock with 4 keys. 3/26/24 – E9 ordered and paid for a new lock for the second-floor medication cart with 4 new keys. Service was provided by a local locksmith. 4/18/24 11:25 AM – During an interview, E2 (DRC) and E9 stated that the medication cart keys were reported missing in February (prior to the missing narcotic incident). E2 stated that the facility emailed the pharmacy to request having the locks on the second-floor medication cart re-keyed or have a new lock installed. The pharmacy did not complete this request prior to the incident of missing narcotics on 3/17/24. E2 also stated that the nursing staff was using a "master key' to open the second-floor medication cart. E2 confirmed that this "master key" was able to open all three medication carts and narcotic boxes within the facility. E9 stated that he ordered the refrigerator door locks on 3/24/24 to replace the one that he had applied on 3/22/24 to secure the second-floor medication cart while the facility awaited the second-floor medication cart lock to be replaced. By utilizing the master key for 30 days without any secondary locking system, the facility failed to ensure that the narcotics were stored in a secured and locked container. This situation occurred from February 21, 2024, to march 22, 2024 when the secondary refrigerator door lock was installed on the second floor medication cart. 2. 4/15/24 During a tour of the facility and interview at approximately 2:00 PM, the Sur-	

Provider's Signature ______________________ Title ______________________ Date ______________________

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	veyor found a medication cart to be in the hallway, unlocked and unattended. Per interview with E18 (LPN), E18 stated that the medication cart was unlocked and was in the hallway with no staff present. E18 locked the cart in the Surveyor's presence. 4/19/24 – Findings were reviewed with E1 (ED), E2 and O1 (Ombudsman) at the exit conference, beginning at approximately 2:30 PM.	
3225.8.4	**Residents who self-administer medication shall be provided with a lockable container or cabinet. This requirement does not apply to medications which are kept in the immediate control of the individual resident, such as in a pocket or in a purse. Facility policies must require that medications be secured in a locked container or in a locked room.** This requirement was not met as evidenced by: Based on record review, interview, and review of other facility documentation, it was determined that for five (R23, R24, R25, R26 and R27) out of five residents sampled for self-administration of medications, the facility failed to provide a medication lock box. Findings include: 1. 3/2/24 – R23 was admitted to the facility. On 4/16/24 at approximately 2:10 PM, the Surveyor found that R23's medications were visible on a shelf in the bathroom. During an interview with R23 at this time, R23 stated the facility did not offer a lock box and she does not lock the apartment door on exit. 2. 10/2/23 – R24 was admitted to the facility. On 4/16/24 at approximately 2:40 PM, the Sur-	1. An RN will complete an re-assessment of R23, R24, R25, R26 to review medications, medication storage, and to determine if they are safe to continue to store and manage their own medications and what do if they have any questions or concerns. They will be offered a lockable medication storage container to store their medications. If unsafe practices are found DRC will have a discussion with the resident and their family explaining that the facility will need to take over the resident's medication management. 2. All residents who self-medicate will be offered a lockable medication container if they do not have one and proper storage will be reviewed with them. 3. RNs and LPNs to be in-serviced by the ED on the need to monitor residents who self-medicate for proper storage of medications. For residents who are admitted verbalizing self-medications, a lockable medication container will be given to them on admission. A column will be added to the self-medication tickler file for medication storage container being offered/given to 100 % of self-medicating residents Policy and procedures have been reviewed and

STATEMENT OF DEFICIENCIES SECTION	SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	veyor found that R24's had dumped white oblong pills into a small basket visible on the coffee table (R24 identified these as Tylenol) and his other medications in a basket by the sofa. During an interview with R24 at this time, R24 stated the facility did not offer a lock box and he or R27 (wife) do not lock the apartment door on exit. 3. 2/12/24 – R25 was admitted to the facility. The Surveyor attempted to interview R25 numerous times and on opening the unlocked apartment door a crack to call their name, the medications were visible on a table right inside the hallway door and along the kitchen counter. Neither resident was in the apartment. During an interview with R25 on 4/17/24 at approximately 3:20 PM, R25 stated the facility did not offer a lock box and he does not lock the apartment door when he or R26 (wife) both exit the apartment. 4. 2/12/24 – R26 was admitted to the facility. The Surveyor attempted to interview R26 numerous times and on opening the unlocked apartment door a crack to call their name, the medications were visible on a table right inside the hallway door and along the kitchen counter. When apartment access was granted, R25 (husband) was the only person in attendance. During an interview with R25 (spouse) on 4/17/24 at approximately 3:20 PM, R25 stated the facility did not offer a lock box for his or R26's medications and he does not lock the apartment door when he or R26 (wife) both exit the apartment. 5. 10/2/24 R27 was admitted to the facility. On 4/16/24 at approximately 2:40 PM, the Surveyor found that R27's medications were visible in a large basket on the coffee table. During	no changes were necessary to achieve regulatory compliance. 4. The tickler file will be reviewed at the QAPI meetings to achieve 100% compliance and for review and recommendations. The frequency of the audits adjusted according to outcomes. Date certain / completion: June 18, 2024



SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	an interview with R27 at this time, R27 stated the facility did not offer a lock box and she or R24 (spouse) do not lock the apartment door on exit. 4/19/24 – Per interview with E1 (ED) at approximately 2:20 PM, E1 stated the facility has lock boxes and will provide them for these self-medicating residents. 4/19/24 - Findings were reviewed with E1 (ED), E2 (DRC) and O1 (Ombudsman) at the exit conference, beginning at approximately 2:30 PM.	
3225.8.6	**Within 30 days after a resident's admission and concurrent with all UAI-based assessments, the assisted living facility shall arrange for an on-site review by an RN of the resident's medication regime if he or she self administers medication. The purpose of the on-site review is to assess the resident's cognitive and physical ability to self-administer medication or the need for assistance with or staff administration of medication.** This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for four (R23, R24, R25 and R27) out of five residents sampled for self-administration of medications, the facility failed to either complete a SAM assessment within 30-days of admission or to ensure the residents who self-administer medications or administer medications to their significant other, that the medications were understood or given appropriately. Findings include: 1. 3/2/24 – R23 was admitted to the facility. The SAM assessment was completed by an RN	1. R23 – an RN will review her medications with her to educate her on what each medication is for and create a list for her to keep with her medications to refer to as needed and to explain that she should talk to a nurse if she has any problems concerning her medications. At the time of her SAM assessments by facility RN, she could name and identify the use of her medications. 2. R 24 original SAM was completed on 10/11/23 and was in the back of his chart. He will be re- assessed for his ability to handle his wife's medication and that will be noted on the SAM assessment form. **3.** R 27 original SAM was completed on 09/15/23 and was in the back of her chart. RN to contact dialysis unit along with her husband (R24) and review R 27 medication regime (what they are giving her) and will review and establish a schedule for at home medication administration times. Residents who self-medicate will have an off-cycle self-medication assessment by an RN to review

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: AL Harbor Chase of Wilmington

DATE SURVEY COMPLETED: April 19, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	on 3/21/24 and on 3/29/24. On 4/16/24 at approximately 2:10 PM per interview with R23 at this time, R23 was unsure as to what the medications were for but relayed that she takes three meds and shared the correct frequency of administration with the Surveyor. E23 stated she was unsure of who to ask at the facility if there were medication changes or issues. E23 did state her daughter lives a few minutes away and handles the reordering of her medications. 2. 10/2/23 – R24 was admitted to the facility. The initial SAM assessment was completed by an RN on 12/14/23, greater than 30-days after admission. SAM assessments were completed on R24 by an RN on 3/21/24 and on 3/29/24. On 4/16/24 at approximately 2:40 PM per interview with R24 at this time, R24 was aware of his medication's usage, side effects, reordering and in handling if discontinued. Per the interview at the above noted time, R24 also stated he handles R27's (wife) medications and stated that he usually pre-pours her day's medications in the morning. The SAM assessment was completed on 12/14/23 for R24 to assist with R27's medication administration. R24 stated on her dialysis days, he adjusts her mid-day medication by doubling up that medication in the evening. R24 was aware of R27's medication's usage, side effects, reordering and in handling if discontinued. During the Surveyor interview, R27 stated that the hemodialysis staff administers her afternoon medication, which was unknown to R24. This medication for hypertension (Midodrine 2.5 mg TID)	ability to continue with self-medications, storage of medications, and questions they may have. There are no other residents who are on dialysis, but in future, the dialysis unit will be contacted on admission to determine what they will be administering vs what resident will be administering. Residents on admission, who desire to manage their own medications will be assessed by the RN for the ability to do so and added to the medication management tickler file to be re-assessed quarterly for continued ability to manage their own medication. RNs and LPNs will be in serviced by the DRC on the need for assessment to ensure that a resident can manage their own medications per regulation/policy and on monitoring for and reporting any concerns about a resident's ability to self-medication to the RN for re-assessment between quarterly reviews. The DRC will maintain the tickler file of 100% of self-medicating residents and updates made as needed. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The tickle file will be reviewed at the QAPI meetings for review and recommendations x three meetings or until 100% compliance. Date certain / completion: June 18, 2024

Provider's Signature ______________________ Title ______________ Date __________

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	was being given four times a day on R24's dialysis days of three times per week for an unknown length of time. 3. 2/12/24 – R25 was admitted to the facility. The SAM assessment was completed by an RN on 3/11/24, Per interview with R25 on 4/17/24 at approximately 3:20 PM, R25 stated he was unsure as to what the medications were for. R25 stated he assists with R26's (wife) medication also but was unable to tell the Surveyor what the medications were or why used. During the interview of R25 at this time, R26 was not in attendance. The SAM assessment done for R26 on 3/20/24 indicated that R26 does her medications "with the help of her husband". At the time of the Surveyor interview, the Surveyor found R25 to have some difficulty in understanding and answering questions. 4. 10/2/23 – R27 was admitted to the facility. The initial SAM assessment was completed by an RN on 12/15/23, greater than 30-days after admission. The SAM assessment indicated R27 was approved for self-administration of her medications. Per interview with both R24 (husband) and R27 on 4/16/24 at approximately 2:40 PM, both R24 and R27 stated that R27 handles R27's medications. Per this interview, R27 stated that the hemodialysis staff administers her afternoon medication, which was unknown to R24. This medication for hypertension (Midodrine 2.5 mg TID) was being given four times a day on R24's dialysis days of three times per week for an unknown length of time. The assessments of residents who self-medicate should capture the resident's knowledge	

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	of the medication's usage, effectiveness, side effects, storage, and changes for any resident self-medicating or in assisting the spouse with their medication regime.	
	4/19/24 – Findings were reviewed with E1 (ED), E2 and O1 (Ombudsman) at the exit conference, beginning at approximately 2:30 PM.	
3225.8.8	**Concurrently with all UAI-based assessments, the assisted living facility shall arrange for an on-site medication review by a registered nurse, for residents who need assistance with self-administration or staff administration of medication, to ensure that:**	
3225.8.8.2	**Each resident receives the medications that have been specifically prescribed in the manner that has been ordered;**	1. Nothing can be done to correct the missing documentation or missed doses of medications for R7, R13, and R29.
	This requirement was not met as evidenced by:	2. All residents have the potential to be affected by this practice.
	Based on review of facility documentation and interview, it was determined that for three (R7, R13 and R29) out of fifteen residents sampled, that the facility failed to provide residents the medications that were prescribed. R7 missed 5 doses of medication, R28 missed 2 doses of medications and R13 had 4 blood sugar checks missed that may have resulted in missing Insulin dosing. Findings include:	3. Nurses and Med Tech to be in-serviced by the DRC on proper documentation of medications administered, missed medications, and blood sugar checks. The facility changed to an EMAR in March 2024 to aid in medication administration, documentation, and compliance review. An audit will be conducted daily of all carts through the EMR by the DRC or designee for improper medication documentation and corrections made within 24 hours until 100% compliance is achieved for 4 weeks. Policy and procedures have been reviewed and no changes were
	1. 3/6/21 – R7 was admitted to the facility with diagnoses, including but not limited to, anxiety disorder, dementia, insomnia and depressive disorder.	
	R7's Physician Orders dated 10/26/23 included, "Alprazolam 0.5 mg- give 1 tablet by oral route twice daily in the afternoon and at bedtime."	

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: AL Harbor Chase of Wilmington

DATE SURVEY COMPLETED: April 19, 2024

STATEMENT OF DEFICIENCIES SECTION	SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	On 3/17/24 at approximately 9:00 AM – Forty-two (42) narcotic medications were reported "missing" from the second-floor medications cart. Due to this incident occurring on a Sunday, there were no providers in house to write new prescriptions for the missing narcotics in order to obtain new medications for the residents whose medications were misplaced. 3/17/24 1 PM – R7's Medication Administration Record (MAR) documented that R7's 1:00 PM Alprazolam 0.5 mg dose was not administered. 4/16/24 - Review of R7's March 2024 MAR revealed that R7 missed a total of five doses of alprazolam (three 1 PM doses and two 8 PM doses). 2. 12/31/23 – R13 moved into the memory care section of the facility and had multiple diagnoses, including dementia, diabetes, and high blood pressure. 4/16/24 – A review of R13's 12/31/23 physician's orders for medications included the following: Novolog Flex Pen. Check blood sugar before meals. If blood sugar is greater than 250 inject 4 units subcutaneous (under the skin). 4/16/24 – Review of R13's January 2024 medication administration record (MAR) revealed that the 11:30 AM blood sugar checks were not in evidence on four (4) out of 20 opportunities: 1/1/24, 1/2/24, 1/11/24 and 1/14/24. 4/18/24 2:00 PM – During an interview, E23 (LPN) confirmed that blood sugar checks for the above dates and times were not present on the January MAR.	necessary to achieve regulatory compliance. 4. Findings will be reported during QAPI meetings for review and recommendations. The frequency of the audits will be adjusted according to outcomes. Date certain / completion: June 18, 2024

Provider's Signature ______________________ Title ______________________ Date ______________

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The lack of blood sugar checks on the above dates and times was relevant because it was unknown if R13 would have had elevated blood sugar levels greater than 250, which would have then required the administration of insulin prior to eating lunch. 3. 7/31/23 – R28 was admitted to the facility with diagnoses, including but not limited to, osteoarthritis, carpal tunnel syndrome right upper extremity and intervertebral disc degeneration lumbar region. R29's Physician Orders dated 7/31/23 documented, "Oxycodone/ Acetaminophen 7.5- 325 mg (milligrams)- take 1 tablet by mouth every night at bedtime for OA (osteoarthritis)." On 3/17/24 at approximately 9:00 AM – Forty-two (42) narcotic medications were reported "missing" from the second-floor medications cart. Due to this incident occurring on a Sunday, there were no providers in house to write new prescriptions for the missing narcotics to obtain new medications for the residents whose medications were misplaced. 4/18/24 -Per record review, R28's MAR documented that R28's 9:00 PM dose of Oxycodone/Acetaminophen 7.5 – 325 mg doses were not administered on 3/17/24 and 3/18/24. R28 missed two doses of her prescribed oxycodone/acetaminophen tablets due to the medication being unavailable after 3/17/24 missing medication incident. 4/18/24 1:45 PM – During an interview, E2 (DRC) stated that when initials are circled on the MAR, it means that the medication was not given at the administration time. E2 stated that the medications were not available for a period of time because the facility had to get a	

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	new prescription for the medication, then request the medication from the pharmacy while ensuring that the resident was not charged for the replacement medications. The facility paid for them. Then the medications had to be delivered from the pharmacy. Due to the incident occurring on a Sunday, this process to replace the medication was not initiated until Monday morning. 4/19/24 – Findings were reviewed with E1 (ED), E2 and O1 (Ombudsman) at the exit conference, beginning at approximately 2:30 PM.	
3225.9.0	**Infection Control**	
3225.9.6	**The assisted living facility shall have on file evidence of annual vaccination against influenza for all residents, as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against influenza must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.** This requirement was not met as evidenced by: Based on interview, record review and other facility documentation, it was determined that for four (R9, R24, R26 and R27) out of seven residents sampled for Influenza vaccine, the facility failed to have evidence on file of an annual vaccination against influenza or a declination of such. Findings include: 1. 6/23/22 – R9 was admitted to the facility. There was no evidence of a 2023 Influenza vaccination being administered or of a declination of such.	1. R9 – had his influenza vaccine administer at the facility on 10/11/23 . An updated DelVax sheet has been printed. R 24 had his influenza vaccine on 10/11/23. An updated DelVax sheet has been printed. R 27 had her influenza vaccine on 10/11/23 . An updated DelVax sheet has been printed. R26 – nothing can be done about her not having the influenza vaccine due to the fact that is out of season. 2. All residents have the potential to be affected by not having their annual vaccinations for influenza. 3. Director of Sales, the DRC, and nurses will be inserviced by the ED on the requirement for a resident to have on record proof of an annual flu vaccine being offered. An audit has been conducted on residents admitted within the last year to determine vaccination status and documents updated. Any resident missing this information will

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	2. 10/2/23 – R24 was admitted to the facility. There was no evidence of a 2023 Influenza vaccination being administered or of a declination of such. 3. 2/12/24 – R26 was admitted to the facility. There was no evidence on file of a 2023 Influenza vaccination being offered, administered or of a declination of such. Per interview with E2 on 4/19/24 at approximately 2:20 PM, E2 stated she was going to reach out to the family to obtain the information. Information received by the Surveyor on 4/22/24 via email from E2, E2 had contacted the daughter by email on 4/22/24 who relayed that she was unsure of R26's vaccination status. 4. 10/2/23 – R27 was admitted to the facility. There was no evidence of a 2023 Influenza vaccination being administered or of a declination of such. 4/19/24 – Per interview with E2 at approximately 2:20 PM, E2 confirmed the Influenza vaccination status was not in evidence. 4/19/24 - Findings were reviewed with E1 (ED), E2 and O1 (Ombudsman) at the exit conference, beginning at approximately 2:30 PM.	be offered the vaccine at our next vaccination clinic. Included in the contract residents sign is a document encouraging vaccination and informing them of the health risks. It also explains how to the facility can help residents obtain vaccines if wanted outside our yearly Vaccination Clinic. After our yearly vaccination clinic, all residents will have the DelVax sheets reprinted or record of declining the vaccine that will be maintained by the facility. The initial UAI will be audited by the Director of Sales or designee to review initial flu vaccination status of residents that are addressed in the UAI. An audit for the flu vaccine compliance on the UAI will be done weekly x 3 and then monthly times two till 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 adjusted according to outcomes. Date certain / completion: June 18, 2024 1. R25 will be offered to be taken to a pharmacy to get the pneumonia vaccine at our annual vaccine clinic.
3225.9.7	**The assisted living facility shall have on file evidence of vaccination against pneumococcal pneumonia for all residents older than 65 years, or those who received the pneumococcal vaccine before they became 65 years and 5 years have elapsed, and as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against pneumococcal pneumonia must be fully informed by the facility of the health risks involved. The reason**	

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	for the refusal shall be documented in the resident's medical record. This requirement was not met as evidenced by: Based on interview, record review and other facility documentation, it was determined that for one (R25) out of seven residents sampled for pneumonia vaccine, the facility failed to have evidence on file of a vaccination against pneumococcal pneumonia or a declination of such. Findings include: 2/12/24 - R25 was admitted to the facility. There was no evidence on file of a pneumococcal pneumonia vaccination being administered or of a declination of such. 4/19/24 – Per interview with E2 at approximately 2:20 PM, E2 confirmed the pneumonia vaccination status was not in evidence. E2 stated she was going to reach out to the family to obtain the information. 4/19/24 - Findings were reviewed with E1 (ED), E2 and O1 (Ombudsman) at the exit conference, beginning at approximately 2:30 PM.	2. All residents have the potential to be affected by not having their vaccinations for flu or pneumonia. 3. Director of Sales, DRC, and nurses will be in-serviced by the ED or sesignee on the requirement for a resident to have on record proof of a pneumonia vaccine being offered. An audit to be conducted on residents by the DRC admitted within the last year to determine vaccination status and documents updated. Any resident missing this information will be offered the vaccine at our next vaccination clinic. Included in the contract residents sign is a document encouraging vaccination and informing them of the health risks. It also explains how to the facility can help residents obtain vaccines if wanted outside our yearly Vaccination Clinic. After our yearly vaccination clinic, all residents will have the DelVax sheets reprinted or record of declining the vaccine that will be maintained by the facility. The initial UAI will be audited by the Director of Sales or designee to review initial pneumococcal vaccination status of residents are addressed in the UAI . The audit for the pneumonia vaccine compliance on the UAI will occur weekly x 3 and then monthly times two till 100% compliance is achieved. Policy and procedures have
3225.10.0	**Contracts**	
3225.10.10	**No contract shall be signed before a full assessment of the resident has been completed and a service agreement has been executed. If a deposit is required prior to move-in, the deposit shall be fully refundable if the parties cannot agree on the services and fees upon completion of the assessment.** This requirement was not met as evidenced by:	

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: AL Harbor Chase of Wilmington

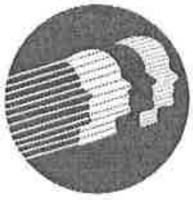
DATE SURVEY COMPLETED: April 19, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Based on review of facility documentation and interview, it was determined that for six (R16, R23, R24, R25, R26, and R27) out of six residents sampled for contract dates, the facility obtained a signed contract prior to a completed UAI or SA (service agreement) being executed. The facility's standard of practice was to have contracts signed prior to assessing whether the facility could meet the needs of the residents in an AL facility and identifying what actual services the facility would provide under the contract. This practice persisted over a period of at least 9 months (June 2023 – March 2024). Findings include: 1. 6/19/23 – R16 was admitted to the facility. The SA was completed on 6/18/23. The contract was signed on 6/16/23, prior to the service agreement being executed. 2. 3/2/24 – R23 was admitted to the facility. The SA was completed on 3/6/24. The contract was signed on 2/29/24, prior to the service agreement being executed. 3. 10/2/23 – R24 was admitted to the facility. The initial UAI was completed on 9/3/23 and the SA was completed on 10/1/23. The contract was signed on 8/31/23, prior to both the UAI and the SA being completed/executed. 4. 2/12/24 – R25 was admitted to the facility. The SA was completed on 2/9/24. The contract was signed on 1/31/24, prior to the service agreement being executed. 5. 2/12/24 - R26 was admitted to the facility. The SA was completed on 2/9/24. The contract was signed on 1/31/24, prior to the service agreement being executed.	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 adjusted according to outcomes. Date certain / completion: June 18, 2024 1. Assessment dates, service plans, and UAI dates cannot be changed for R16, R24, R25, and R 26. 2. All residents on admission could have been affected by this process and dates of assessments, service plans, and UAI's cannot be changed 3. RNs and Director of Sales (DOS) were in-service by ED on proper processes and time frames for documentation related to pre- admission UAI, Service Plans, and Contract Signing. Procedure was changed to assure the UAI and service plan is completed and signed on our before the signing of the contract by the ED. An audit form showing dates of UAI, service plan and contract signing will be kept by the DOS with each admission. The audit will be reviewed by the ED or designee weekly to assure compliance to UAI and service plan completion prior to contract signage weekly x four and then monthly x two months until 100% compliance. Policy was reviewed and no changes were necessary to achieve regulatory compliance.

Provider's Signature ______________ Title ______________ Date ______________

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	6. 10/5/23 – R27 was admitted to the facility. The SA was completed on 10/1/23. The contract was signed on 8/31/23, prior to the service agreement being executed. 4/16/24 – Per interview with E4 (BOM) at approximately 2:30 PM, E4 confirmed the contract signature dates. 4/19/24 – Findings were reviewed with E1 (ED), E2 (DRC) and O1 (Ombudsman) at the exit conference, beginning at approximately 2:30 PM.	4. Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes. Date certain / completion: June 18, 2024
3225.11.0	**Resident Assessment**	
3225.11.5	**The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.** This requirement was not met as evidenced by: Based on record review, interview, and review of other facility documentation, it was determined that for two (R16 and R23) out of six residents sampled for UAI assessments, the facility lacked evidence of a completed 30-day UAI after admission. Findings include: 1. 6/19/23 – R16 was admitted to the facility. The 30-day UAI was not in evidence. 2. 3/2/24 – R23 was admitted to the facility. The 30-day UAI was not in evidence. 4/9/24 – Per interview with E2 (DRC) at approximately 2:20 PM, E2 confirmed these 30-day UAIs were not in evidence.	1. R 16 and R23 30-day review was completed but not signed. R 16 has been discharged from the facility. R 23 UAI 30 day will be signed by assessor dated the current date it is being signed. 2. All residents have the potential to be affected by this practice. 3. The DRC was in-service by the ED on the UAI assessment for the required 30 day UAI review after admission. Policy was reviewed and no changes were necessary to achieve regulatory 100 % compliance.

STATEMENT OF DEFICIENCIES SECTION	SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	4/19/24 – Findings were reviewed with E1 (ED), E2 and O1 (Ombudsman) at the exit conference, beginning at approximately 2:30 PM.	4. The ED or designee will audit all admission UAI's for the signature of the RN at the 30-day review prior to filing in resident charts. This audit will occur weekly times four and monthly times two. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. Findings will be reported to the QAPI committee for 100% compliance, review and recommendations. The frequency of the audits adjusted according to outcomes.
3225.12.0	**Services**	Date certain / completion: June 18, 2024
3225.12.1	**The assisted living facility shall ensure that:**	1. No resident was sited or affected by this practice.
3225.12.1.3	**Food service complies with the Delaware Food Code Delaware Food Code** **Delaware Food Code 3-401.11 Raw Animal Foods: (A) Except as specified under (B) and in (C) and (D) of this section, raw animal FOODS such as EGGS, FISH, MEAT, POULTRY, and FOODS containing these raw animal FOODS, shall be cooked to heat all parts of the FOOD to a temperature and for a time that complies with one of the following methods based on the FOOD that is being cooked.** This requirement was not met as evidenced by: Based on observations, interview, and review of other facility documentation it was determined that the facility failed to comply with the Delaware Food Code. Meal temperature logs were incomplete for 102/549 available checks meaning over 18% of mealtime temp logs were incomplete. Findings include: 4/16/24 – 1:00 PM - During the survey of the facility, 549 meal temperature logs were reviewed. During interview with E7 (DOH) at that time, E7 stated the facility was missing 102 mealtime temperature logs out of the 549 reviewed. 4/16/24 - Findings were reviewed with E7 (DOH) at 1:40 PM and with E1 (ED) at 2:45 PM.	2. All residents have the potential to be affected by this practice. No temperature logs for mealtime foods from the past may be altered. The Director of Hospitality has put a monitoring system in place for the closing manger to sign off for completion of taking daily /mealtime temperatures after the State survey team reported this deficiency. 3. It was determined that the line cooks were not taking meal temperatures on a consistent basis. The DOH or designee has in-serviced all food service workers on the process for completing meal temperature logs. The DOH or designee has also in-serviced hospitality managers to audit the meal temp logs daily for 100 % completeness and to correct immediately as



SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
		appropriate, then report to the DOH. The DOH or designee will audit the meal temp logs weekly x 3 then monthly for two months and report finding to the QAPI committee. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The Director of Hospitality or designee will audit meal temperature logs per Delaware's food code weekly times 3 weeks then monthly till 100% precent compliance is achieved. Findings will be reported during the QAPI meetings for review and recommendations. The frequency of the audits adjusted according to outcomes. Date certain / completion: June 18, 2024
3225.13.0 3225.13.3	**Service Agreements** **The resident's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number.** This requirement was not met as evidenced by: Based on policy review, interview and review of other facility documentation, it was determined that six (R16, R23, R24, R25, R26, and R27) out of six residents sampled service agreements, the facility failed to provide personal Attending Physician information on the SA (service agreement). Findings include: 1. 6/19/23 – R16 was admitted to the facility. The SA was completed on 6/18/23 and did not contain the personal Attending Physician name, address or phone number. 2. 3/2/24 – R23 was admitted to the facility. The SA was completed on 3/6/24 and did not contain the personal Attending Physician name, address or phone number. 3. 10/2/23 – R24 was admitted to the facility. The SA was completed on 10/1/23 and did not contain the personal Attending Physician name, address or phone number. 3. 2/12/24 – R25 was admitted to the facility. The SA was completed on 2/9/24 and did not contain the personal Attending Physician name, address or phone number. 4. 2/12/24 - R26 was admitted to the facility. The SA was completed on 2/9/24 and did not contain the personal Attending Physician name, address or phone number.	1. The DRC or designee will add the physician's name, address, and phone number will be added to R23, R27, and R26 service plans. R16 has been discharged. 2. All residents had the potential to be affected by this practice. An audit by DRC or designee of all current residents admitted in the last six months will be conducted by DRC or designee and if needed, the service plan will be updated indicating the resident's attending physician's name, address, and phone number by DRC or designee. 3. The DRC and RNs will be in-serviced by the ED on the policy to include the physician's name, address, and phone number on the resident's service plan. The ED will audit all new admissions service plan for admitting physicians' information on service

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	5. 10/2/23 – R27 was admitted to the facility. The SA was completed on 10/1/23 and did not contain the personal Attending Physician name, address or phone number. 6. R28 was admitted to the facility. The SA was completed on 10/1/23 and did not contain the personal Attending Physician name, address or phone number. 4/19/24 – Per interview with E2 (DRC) at approximately 2:20 PM, E2 confirmed the SA forms being utilized at the facility, do not contain the personal Attending Physician information. 4/19/24 - Findings were reviewed with E1 (ED), E2 and O1 (Ombudsman) at the exit conference, beginning at approximately 2:30 PM.	plans prior to signing them and will return to RN assessor for completion of information is not found on service plan. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. Findings will be reported during the QAPI meeting x 3 meetings for review and recommendations. The frequency of the audits adjusted according to outcomes. Date certain / completion: June 18, 2024
3225.16.0	**Staffing**	
3225.16.13	**The Director of Nursing shall have overall responsibility for the coordination, supervision and provision of the nursing department /services.** This requirement was not met as evidenced by: Based on review of facility documentation and interviews, it was determined that the Director of Nursing did not supervise the facility's nursing services on 12/31/23 when R13 moved into the facility; R13 did not have a nursing assessment for approximately five hours. Cross refer to 16 Delaware Code, Neglect. Findings include:	1. No corrective actions can be taken for R13 because she has been discharged.

Provider's Signature ______________ Title ______________ Date ______________

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	12/31/23 – R13 moved into the memory care section of the facility and had multiple diagnoses, including dementia, diabetes, and high blood pressure. 4/15/24 – During an interview, F1 stated that she moved R13 into the facility's memory care unit on 12/31/23 at 10:00 AM. F1 stated that R13 did not have a nursing assessment or have her blood sugar checked from 10:00 AM until the time that F1 left the facility at 3:00 PM. F1 stated that R13 ate lunch at the facility on 12/31/23 without having her blood sugar checked before the meal. A review of the Director of Resident Care Job Description, Position Summary document, prepared 1/2015, revealed: - Supervise delivery of resident care provided by licensed and non-licensed nursing personnel.... A review of the 12/31/23 facility staffing sheet revealed that the memory care unit did not have a nurse assigned to the unit from 7:00 AM – 3:00 PM. 4/17/24 3:30 PM – During an interview E2 (RN, DRC) stated that she worked in the facility until approximately 6:30 PM on 12/31/23, and that she had been unaware that R13 had moved into the memory care unit on 12/31/23. 4/19/24 - Findings were reviewed with E1 (ED), E2 and O1 (Ombudsman) at the exit conference, beginning at approximately 2:30 PM.	2. Any new admission could be affected by this situation. 3. Nurses, med techs, care partners, and concierges, will be in-service by DRC on notification to a nurse of the arrival of a new resident in the building even if that nurse is not working in the area the resident is being admitted to, so the nurse can assess. Guidelines to the admission process have been changed to include that diabetic residents should not be admitted on a weekend nor if a nurse is not in the building. All new admissions will be audited for 100 % compliance with the guidelines will be reviewed monthly for three months by ED or designee. 4. Findings will be reported during the QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes. Date certain / completion: June 18, 2024
3225.16.14	**Assisted living facility resident assistants shall, at a minimum:**	
3225.16.14.1	**Be at least 18 years old;**	

Provider's Signature ______________________ Title ______________ Date ____________

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: AL Harbor Chase of Wilmington **DATE SURVEY COMPLETED:** April 19, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3225.16.14.2	**Participate in a facility-specific orientation program that covers the following topics:**	
3225.16.14.2.1	**Fire and life safety, and emergency disaster plans;**	
3225.16.14.2.2	**Infection control, including Standard Precautions;**	
3225.16.14.2.3	**Basic food safety;**	
3225.16.14.2.4	**Basic first aid and the Heimlich Maneuver;**	
3225.16.14.2.5	**Job responsibilities;**	
3225.16.14.2.6	**The health and psychosocial needs of the population being served;**	
3225.16.14.2.7	**The resident assessment process; and**	
3225.16.14.2.8	**The use of service agreements;**	1. No resident was affected by this practice. E14, E24, and E31 completed all State Mandated training on the communities Relias program after the survey team sited these employees on 4/18/24.
3225.16.14.2.9	**16 Del.C. Ch. 11, pertaining to residents' rights; reporting of abuse, neglect, mistreatment, and financial exploitation; and the Ombudsman Program;**	
3225.16.14.2.10	**Hospice services.**	2. All residents have the potential to be affected by this practice. The Business office manager conducted an audit of all nursing staff that has transferred from another department to nursing for compliance on State mandated annual training.
3225.16.14.3	**Receive, at a minimum, 12 hours of regular in-service education annually which may include but not be limited to the topics listed in 16.14.2;**	3. It was determined the three sited employees had not completed the State mandated annual training after they transitioned to nursing from another department. The BOM completed an audit to identify employees that have transitioned to the nursing depart-
3225.16.14.4	**Receive training to competently assist in activities of daily living or provide documentation of such training, and ...** This requirement was not met as evidenced by:	

Provider's Signature ____________ Title ____________ Date ____________

STATEMENT OF DEFICIENCIES SECTION	SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Based on review of facility documentation and interviews, it was determined that for three (E14, E24 and E31) out of three sampled employees the facility failed to provide mandatory education in all aspects of the facility-specific orientation employees who function dually as their initial hire job in the facility and as care partners. Findings include: 1. 1/24/20 - E14 was hired full time at the facility as a Utility worker. 2. 10/26/23 - E24 was hired part time at the facility as a Housekeeper. 3. 9/12/23 – E31 was hired full time at the facility as a Utility worker. 4/19/24 – Per interview with E2 (DRC) at approximately 10:35 AM, E2 stated the Care Partner is the term the facility uses for the role of nurse's aide. E2 stated that a Utility worker helps where the facility needs it e.g., kitchen, housekeeping, care partners, etc. E2 provided documentation that proved that E31 was "hands-on" cross-trained for the role of Care Partners for five days in August 2022, E14 was "hands-on" cross-trained for the role of Care Partners for five days in November 2023, and E14 was "hands-on" cross-trained for the role of Care Partners for five days in January 2024. 4/19/24 – Per interview with E1 (ED) at approximately 10:35 AM, E2 confirmed that the facility utilized a well-known online education company to provide the regulatory compliance training that aligns with the mandatory education for nursing aides in the assisted living environment. E1 confirmed that the facility did not have evidence that E14, E24 and E31 had completed the full mandatory educational train-	ment to ensure that they will receive the appropriate State mandated education. That BOM will conduct a weekly audit x3 than monthly x 2 of employees that transition to another department to ensure they receive the appropriate annual training. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The BOM or designee will audit all employees training records that have transitioned to nursing weekly x 3 then monthly x 2 to ensure they have received the appropriate State mandated annual nursing training until 100% compliance must be achieved. Findings will be reported to the QAPI committee for review and recommendations x 3 meetings and the frequency of the audits adjusted according to outcomes. Date certain / completion: June 18, 2024

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: AL Harbor Chase of Wilmington

DATE SURVEY COMPLETED: April 19, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	ings. E1 stated that the online trainings are uploaded to the employes education profile based on the job that human resources documented in their profile. The facility failed to add their new job description to their online education profile which would have prompted these mandatory trainings to be added to their curriculum. 4/19/24 - Findings were reviewed with E1 (ED), E2 and O1 (Ombudsman) at the exit conference, beginning at approximately 2:30 PM.	
3225.19.0	**Records and Reports**	
3225.19.1	**The assisted living facility shall be responsible for maintaining appropriate records for each resident. These records shall document the implementation of the service agreement for each resident.**	
3225.19.2	**Records shall be available, along with the equipment to read them if electronically maintained, at all times to legally authorized persons; otherwise such records shall be held confidential.** This requirement was not met as evidenced by: Based on record review and interview, it was determined that the facility failed to have some records readily available for review by the Survey team. The facility failed to provide R9's EMR entries between 10/2/23 and 3/10/24. The facility failed to provide evidence of a current POA agreement on R18. Findings include: 1. Cross reference Tag 5.0 2. 6/23/22 - R9 was admitted to the facility. R9's electronic notes were not accessible by	1. Residents were not affected by this practice. Resident R18 POA paperwork has been obtained for the community and is maintained in the BOM files. At this time nothing can be done about the lost data during the Yardi transition for R9 and R24. IT from the Yardi team is currently trying to recover the lost data for both R9 and R24.

Provider's Signature ______________ Title ______________ Date ______________

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	the Surveyors or the facility staff before a certain date. 4/17/24 - Per interview and attempts made by both E2 (DRC) and E18 (LPN) to access R24's records from 10/2/23 through 3/10/24, both stated they were unable to pull up these notes. E2 stated she was contacting the EMR provider to find out why some data was not available. 3. 2/28/20 – R18 was admitted to the facility. 6/11/20 – R18 signed a General durable Power of Attorney that was prepared by a Wilmington law firm that named her two sons as her agents. 6/12/20 – R18 signed Durable Power of Attorney naming E32 (former ED) and E33 (secondary POA), who both work for a senior advisor company as R18's Attorneys-in-fact (Power of Attorney). 4/16/24 12:40 PM – During an interview, E1 (ED) confirmed that E32 and E33 were still R18's Power of Attorney. Surveyor was unable to find evidence of the active POA paperwork (dated 6/12/20) in R18's chart or electronic medical record (EMR). 4/16/24 3:50 PM – During an interview, E4 (BOM) stated, "I don't have a copy of R18's [senior advisor company] POA paperwork. Can I call E32 (former ED) to get a copy?"' The facility failed to maintain and have available appropriate POA paperwork for R18. 4/19/24 – Findings were reviewed with E1, E2 (DRC) and O1 (Ombudsman) at the exit conference, beginning at approximately 2:30 PM.	2. All residents with a POA could be affected by this practice. The BOM has completed an audit to ensure residents POA paperwork is current, and that the community has a hard copy of the POA agreement on file in HarborChase of Wilmington's business office. If and when there is another Yardi update the community will back up the residents nurses notes locally to ensure data is not lost. 3. It was determined that R18 POA paperwork was not maintained in HCW business office. The BOM was in-serviced by the Executive director to include and maintain a hard copy of the POA's current paperwork in the resident's admissions packet/file. The BOM will add a line on the admissions packet check off list that indicates the file is complete with the POA's paperwork as appropriate. The BOM has in-service her assistant (concierge) to ensure the process to obtain the POA's paperwork is complete and in the resident's file. The BOM or designee has conducted an audit of all the resident's admission files, that have a POA, to include a current copy of the POA's paperwork. If and when there is another Yardi update, the community will complete an audit of the backed up for residents nurses notes to ensure data, going back to the residents' admission date, is not lost. The findings will be reported to the NHA and present at the QAPI's committee meeting quarterly. Policy and procedures have been reviewed and no changes were

STATEMENT OF DEFICIENCIES SECTION	SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3225.19.6	**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.**	necessary to achieve regulatory compliance. 4. The BOM will audit the resident admission files for residents that have a POA weekly x 3 then monthly times 2. Compliance expectations are for 100% compliance. Findings will be reported to the QAPI committee for review and recommendations x 3 meetings and the frequency of the audits adjusted according to outcomes.
3225.19.7	**Reportable incidents include:**	
3225.19.7.1.1	**Physical abuse.**	
3225.19.7.1.1.1	**Staff to resident with or without injury.** This requirement was not met as evidence by: Based on a review of medical records, facility and the Division documentation, it was determined that for one (R16) out of seven residents sampled, the facility failed to report a reportable incident within the State regulation of within 8 hours. Findings include: 6/19/23 – R16 was admitted to the facility. Review of a 7/2/23 facility Incident Form and staff statements review, revealed that E21 (CP) witnessed E20 (CP) hitting/slapping R16 on her hand and buttocks at 6:00 PM. According to E21, R16 was screaming for the CP "not to hit her again." E20 was immediately removed from the facility per E1 (ED) and with investigative confirmation of abuse, E20's employment was terminated. E16 was assessed by E27 (LPN) after the incident and by the Nurse Practitioner the following day and was noted to be unharmed. While the facility addressed and handled the incident with appropriate steps, this incident occurred on 7/2/23 at 6:00 PM and reported to the State on 7/3/23 at 12:23 PM, over 8 hours later.	Date certain / completion: June 18, 2024 1. Resident R16 no longer resides in the community. The incident for R16 was reported the very next day when the community realized that the incident hadn't been reported by the supervising nurse as instructed by the NHA. E20 was immediately removed from the community. 2. All residents have the potential to be affected by this practice. The DRC / designee will in-serviced the professional nursing staff on the Delaware's requirements for reporting abuse. 3. The supervising nurse during the time of the incident failed to report the incident to the state during the required time(8hrs) period. The DRC or designee will in-service the nursing professional staff on the Delaware state incident reporting requirements and to notify DRC

Provider's Signature ______________ Title ______________ Date ______________

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	4/19/24 - Findings were reviewed with E1, E2 (DRC) and O1 (Ombudsman) at the exit conference, beginning at approximately 2:30 PM.	and or NHA when the reportable is entered into the State's incident reporting system. All incident reports will be reviewed by the DRC or designee to ensure an incident was reported appropriately. Finding will be noted to the Chairman of the QAPI committee. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The finding will be reviewed by the QAPI committee for 100% compliance x three meetings and the QAPI committee will make recommendations related to outcomes. Date certain / completion: June 18, 2024
3225.19.7.2	**Neglect as defined in 16 Del.C. §1131.** Based on a search of the State Survey Agency reporting system and a review of documented communication between FM1 (the daughter of R3) and facility staff it was determined that the facility failed to immediately report neglect to the State Survey Agency on at least four different dates over a two-month time frame (1/31/24 - 3/31/24) Findings include: The State Survey Agency reporting system contains no facility reported neglect of R3 despite the following documented reports of neglect made directly to facility staff. -Email from FM1 dated 1/31/24 12:22 AM to E2 (DRC) and E5 (DMC): FM1 reported that R3 was left sitting saturated and soiled (urine and feces), was left in bed for over 14 hours, and was not being washed. In an email dated 2/1/24 3:43 pm, FM1 thanked E1 (ED), E2, and E5 for meeting with her that day to discuss these concerns. The facility failed to report FM1's report of neglect to the State Survey Agency immediately or at all. -Text message 2/23/24 7:19 PM to E5 from FM1: R3 found with two pull ups and two guards (a type of incontinence pad) soaked in urine E5 acknowledged this report by questioning staff using pull ups "again" and writing that	1. R3 resides in the community. Staff provided care at the time of these incidents. 2. All residents could be affected by this practice. 3. The DRC or designee will in-service the nursing professional staff and management on the Delaware state incident reporting requirements and to notify DRC and/ or NHA when the reportable is entered into the State's incident reporting system and on what could be considered neglect All incident reports will be reviewed by the DRC or designee to ensure an incident was reported appropriately. Finding will be noted to the Chairman of the QAPI committee. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance.

DELAWARE HEALTH AND SOCIAL SERVICES

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

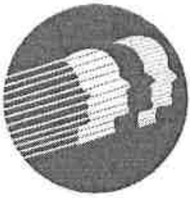
DHSS - DHCQ
263 Chapman Road, Suite 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

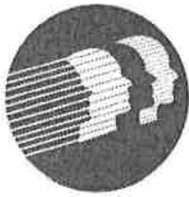
NAME OF FACILITY: AL Harbor Chase of Wilmington **DATE SURVEY COMPLETED:** April 19, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	staff should not put two briefs on R3. The facility failed to report FM1's report of neglect to the State Survey Agency immediately or at all. -Text message 3/26/24 4:57 PM responded to by E1: Photo of urine saturated disposable undergarment with description by FM1 that R3 was "wet all through his clothes, his new seat cushion, and his wheelchair" E1 asked if staff had refused to change R3 and FM1 replied "I believe it's just habit that they don't change, check or toilet him during the day. He just sits in it". The facility failed to report FM1's report of neglect to the State Survey Agency immediately or at all. -Text message 3/31/24 2:03 PM FM1 to E1 and E5 acknowledged by E5: Photo of wet appearing disposable undergarment with yellow staining and a description that R3 wasn't changed all day and "reeked of urine". E5 responded that she didn't know why R3 wouldn't have been changed and she would speak to the assigned staff the next day. The facility failed to report FM1's report of neglect to the State Survey Agency immediately or at all.	4. The finding will be reviewed at the QAPI committee for 100% compliance for three meetings and the QAPI committee will make recommendations related to outcomes. Date certain / completion: June 18, 2024
3225.19.7.7.2	**Injury from a fall which results in transfer to an acute care facility for treatment or evaluation or which requires periodic reassessment of the resident's clinical status by facility professional staff for up to 48 hours.** This requirement was not met as evidenced by:	

Provider's Signature ______________________ Title ______________________ Date ____________



SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Based on a review of medical records, interview, facility, and the Division documentation, it was determined that for two (R9 and R13) out of fifteen residents sampled for post fall assessments, the facility failed to report or timely report a reportable incident. Findings include: 1. 6/23/22 - R9 was admitted to the facility. Per EMR entry on 2/16/24 R9 sustained a witnessed fall by R4 (another memory care resident). E35 (LPN) noted in the EMR at 10:28 AM, that R9 was non-compliant in using his walker and fell. He was found siting on the floor by E35 (LPN) who did the assessment post fall. E35 indicated that R9 denied hitting his head, however a skin tear over his left brow area required steri-strips and monitoring of R9's status post fall. Per EMR entry by E23 (LPN) on 2/17/24 at 12:29 PM, E23 indicated post fall with injury. Bruising was noted on R9's face and he was being monitored closely to prevent further falls. Five subsequent assessments done 2/17/24 at 12:19 AM by E29 (LPN), at 1:25 PM by E23, at 5:23 AM by E36 (LPN), on 2/18/24 at 5:23 AM by E36, and on 2/19/24 at 5:13 AM by E 37(LPN) were all titled "Alert Charting-Fall with Injury". 4/19/24 – Per interview with E1 (ED) at approximately 2:20 PM, E1 stated that R9 fell forward near entrance of his room onto his knees grazing the handrail as he fell and got a skin tear near his left eyebrow. E1 stated that resident was assessed and R9 denied hitting his head. R9 was assessed by the LPN as to not needing to be evaluated in the ER. Per E1 this incident was reported when R9 again fell on 2/28/24 and	1. Nothing can be done for R9. He was treated at the time the fracture was discovered. R13 has been discharged. 2. All residents who fall have the potential to be affected by this practice. 3. Nurses, med techs, and managers will be in-service by DRC regarding transfer of a resident to an acute setting for assessment after injury or a condition that requires periodic reassessment for up to 48 hours and the reporting requirements for that event. It will include the policy to transfer residents to a doctor's care, urgent care, or ER if the resident injuries their head from a fall. The ED or designee will audit 100% of incident reports to ensure appropriate evaluation of a resident with any head injury from a fall and that the community is reporting according to regulatory compliance for incident reporting daily for two months and then weekly until 100% compliance is achieved. Policy and procedures have been reviewed and no



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: AL Harbor Chase of Wilmington

DATE SURVEY COMPLETED: April 19, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	was sent to the ER after falling and hitting the back of his head. The ER assessment record indicated R9 had suffered from an acute zygomatic Arch (cheekbone) fracture and an anterior wall of the left maxillary sinus fracture. R9 was placed on antibiotics and returned to the facility. The facility failed to report the 2/16/24 fall which required steri-stips to R9's brow, development of facial bruising and monitoring of R9's post fall status. 2. 12/31/23 – R13 moved into the memory care section of the facility. Review of a 1/3/24 facility Incident Form revealed that R13 had an unwitnessed fall in her room at 8:30 AM, and that R13 had a bruise to the right side of her head. R13 required periodic reassessment from the 1/3/24 fall. Electronic medical record (EMR) progress notes 1/3/24 through 1/5/24 revealed that R13 was monitored and assessed by nursing staff related to her 1/3/24 fall with head injury including: 1/4/24 1:54PM – An EMR progress note revealed "Resident post fall with abrasion to right side of head new order (sic) was received "to clean area with NS and leave open to air. ...Staff to monitor site for signs of worsening." 4/18/24 – The facility did not submit a report to the State of R13's 1/3/24 unwitnessed fall with head injury that required periodic reassessment of the resident's clinical status by facility professional staff for up to 48 hours. 4/19/24 - Findings were reviewed with E1 (ED), E2 (DRC) and O1 (Ombudsman) at the exit conference, beginning at approximately 2:30 PM.	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. Date certain / completion: June 18, 2024

Provider's Signature ______________________ Title ________________ Date ____________

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: AL Harbor Chase of Wilmington

DATE SURVEY COMPLETED: April 19, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	16 Delaware Code, Chapter 11, Subchapter III **Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents. (81 Del. Laws, c. 206, § 31; 83 Del. Laws, c. 22, § 1.)** **12) "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect includes all of the following:** **a. Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety.** This requirement was not met as evidenced by: Based on record review, investigative review, interview and review of other facility and partnering services documentation, it was determined that for two (R9, R13) out of two sampled residents for neglect, the facility failed to provide the medical attention to R9's physical needs. As a result of a lack of medical evaluation, a R9 had unidentified facial fractures x 12 days until the resident fell again and was sent to the emergency department where the facial fractures were identified. The facility failed to provide an admission assessment to oversee medical care and monitor the status of a R13 for approximately 5 hours after her admission resulting in possible delay in Insulin administration or other medical issue. Findings include: 1. 6/23/22 - R9 was admitted to the facility. Per EMR entry on 2/16/24, R9 sustained a witnessed fall by R4 (another memory care resident). E35 (LPN) noted in the EMR at 10:28 AM, that R9 was non-compliant in using his walker and fell. He was found siting on the floor by E35	1. R9 was treated at the time the fracture was discovered. R 13 has been discharged. 2. All residents who fall or newly admitted have the potential to be affected by this practice. 3. Nurses, med techs, and managers will be in-service by DRC regarding transfer of a resident to an acute setting for assessment after injury or a condition that requires periodic reassessment for up to 48 hours and the reporting requirements for that event. It will include the policy to transfer residents to a doctor's care, urgent care, or ER if the resident injuries their head from a fall. The ED or designee will audit 100% of incident reports to ensure appropriate

Provider's Signature ______________________ Title ______________________ Date ______________

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: AL Harbor Chase of Wilmington

DATE SURVEY COMPLETED: April 19, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	(LPN) who did the assessment post fall, indicated R9 denied hitting his head, however a skin tear over his left brow area required steri-strips and monitoring of R9's status post fall. Per EMR entry by E23 (LPN) on 2/17/24 at 12:29 PM, E23 indicated "post fall with injury." Bruising was noted on R9's face and he was being monitored closely to prevent further falls. On 2/28/24 R9 again fell and stated he hit the back of his head. R9 was sent to the ER after this fall to rule out head injury. 2/28/24 – The ER assessment record indicated R9 had suffered from an acute Zygomatic Arch (cheekbone) fracture and an anterior wall fracture of the left maxillary sinus, most likely from the previous fall. R9 was placed on antibiotics and returned to the facility. 3/6/24 - The submitted information by E2 (DRC) to the State reporting division, E2 indicated that on 2/16/24 R9 had fallen forward to his knees, grazing the handrail and got a skin tear over his left eyebrow which required steri-strips and a band aid. E2 indicated that bruising developed over the next several hours over R9's cheekbone where his glasses sit. 4/19/24 – Per interview with E1 (ED) at approximately 2:20 PM, E1 stated that R9 fell forward near entrance of his room onto his knees and his face slid along the handrail as he fell and got a skin tear near his left eyebrow. E1 stated that resident was assessed and R9 denied hitting his head. R9 was assessed by the LPN as to not needing to be evaluated in the ER. Per E1 this incident was reported when R9 was evaluated in the ER on 2/28/24 after R9 again fell and stated he hit the back of his head. E1 indicated	evaluation of a resident with any head injury from a fall and that the community is reporting according to regulatory compliance for all incident reporting daily for two months and then weekly until 100% compliance is achieved. Nurses, med techs, care partners, and concierges, will be in-serviced by the DRC on notification to a nurse of the arrival of a new resident in the building even if that nurse is not working in the area the resident is being admitted to, so the nurse can assess. Guidelines to the admission process have been changed to include that diabetic residents should not be admitted on a weekend nor if a nurse is not in the building. An audit of all admissions for time of arrival and time of nurse notification for 100 % compliance with the guidelines will be reviewed monthly for three months by ED or designee. 4. Findings will be reported during the QAPI meetings for review and recommendations. The frequency of the audits adjusted according to outcomes. Date certain / completion: June 18, 2024

Provider's Signature ______________________ Title ______________ Date ____________

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	that the facial fractures were most likely due to the previous fall on 2/16/24. The facility reported the 2/16/24 fall after the ER visit on 2/28/24 due to another fall where R9 stated he hit the back of head. This ER assessment/diagnosis reported facial fractures. 4/19/24 – Per interview with E2 at approximately 2:20 PM, E2 confirmed this reported information and stated the complaint was entered as neglect per the State's direction. E2 confirmed there was no documentation of an assessment by an RN or Physician after the 2/16/24 fall. The facility failed to produce evidence of R9's assessment by an RN or Physician after his 2/16/24 fall resulting in injury or after the bruising over R9's face/cheekbone was noted one day later. This lack of a medical assessment after the 2/16/24 fall resulted in delayed treatment of R9's facial injury for 12 days. 2. 12/31/23 – R13 moved into the memory care section of the facility and had multiple diagnoses, including dementia, diabetes, and high blood pressure. R13 had 12/31/23 physician orders for the following: - Obtain a blood sugar check before meals, and if the blood sugar is over 250 give four (4) units of insulin. -Administer twenty-two (22) units of insulin at bedtime. 4/15/24 – During an interview, F1 stated that she moved R13 into the facility's memory care unit on 12/31/23 at 10:00 AM and that they were oriented to R13's room by a staff member from the memory care unit. F1 stated that R13 did not have a nursing assessment or have her	

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: AL Harbor Chase of Wilmington

DATE SURVEY COMPLETED: April 19, 2024

STATEMENT OF DEFICIENCIES SECTION	SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	blood sugar checked from 10:00 AM through 3:00 PM, when F1 left the facility. F1 stated that R13 ate lunch at the facility on 12/31/23. A review of the facility 12/31/23 staffing roster revealed that E26 (RN) worked in the assisted living unit of the facility from 8:00 AM-1:00 pm. 4/17/24 3:00PM – During an interview, E26 confirmed that she worked in the assisted living section of the facility on 12/31/23 from 8:00 AM-1:00 PM, but that she had not been told by memory care staff that a new resident had moved into the memory care unit. E26 stated that if she had been told that a new resident had moved in, she would have done the nursing assessment. A review of the facility 12/31/23 staffing roster revealed that E27 (LPN) worked in the facility's memory care unit from 3:00 PM -11:00 PM. 1/1/24 12:47 AM - A progress note was written by E27 that revealed: "According to the POA, resident arrived at the facility at 10 AM. she (sic) was received by one of the care partner (sic) and oriented to her room. Checked resident's blood sugar (327) and was given (sic) evening insulin as per order...." The note further described that R13's blood pressure was taken and her skin was assessed by E27. 4/18/24 10:00 AM – During an interview, E28 (CP) stated that if she ever had worked on a unit that did not have a nurse, and a new resident moved in, that she would take the resident's vital signs, and then let the nurse on the other unit know that a new resident had arrived, so that the nurse could do the rest of the resident's assessment.	

Provider's Signature ______________________ Title ______________________ Date ______________

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The facility failed to monitor a new resident with diabetes and high blood pressure on her first day in the memory care unit. R13's blood pressure and diabetes blood sugar assessment were delayed for more than five (5) hours. Additionally, the facility failed to have a process to ensure the communication that a new resident had moved into the facility. 4/19/24 - Findings were reviewed with E1, E2 and O1 (Ombudsman) at the exit conference, beginning at approximately 2:30 PM.	

Provider's Signature ______________________ Title ______________________ Date ______________