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: The Pointe at South Harmony Place **DATE SURVEY COMPLETED: March 12, 2026**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Complaint survey was conducted at this facility from February 24, 2026, through February 26, 2026, with a follow-up visit on March 12, 2026. The deficiencies contained in this report are based on observation, interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was thirty-four (34). The survey sample totaled four (4) residents. Abbreviations/definitions used in this state report are as follows: Dementia - loss of mental functions such as memory and reasoning that was severe enough to interfere with a person's daily functioning; DON – Director of Nursing; ED – Executive Director; Elopement – situation where a resident leaves the facility unsupervised and without staff knowledge, posing significant safety risks; Hallucinations – something that seems real but does not really exist; HSD – Health Services Director; LPN – Licensed Practical Nurse; MD – Medical Doctor; Mg – milligrams/unit of weight; MT – Maintenance Technician; Neurocognitive disorder – conditions characterized by a decline in cognitive function due to medical diseases affecting memory, reasoning, and daily functioning;		

Provider's Signature [signature] Title E.P. Date 5-1-2026

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	POA – Power of Attorney/resident representative; Psychiatry – branch of medicine focused on the diagnosis, treatment and prevention of mental, emotional and behavioral disorders; Psychotic – a condition where a person loses touch with reality; RN – Registered Nurse; Seroquel – also known as Quetiapine/antipsychotic medication; Service Agreement – written document developed with each resident which describes what services will be provided, who will provide the services, when the services will be provided, how the services will be provided, and, if applicable, the expected outcome; SLUMS – Saint Louis University Mental Status exam/brief cognitive screening tool designed to detect mild cognitive impairment and dementia; SNF – skilled nursing facility; UAI – Uniform Assessment Instrument/written document to collect information regarding an assisted living applicant/resident's physical condition, medical status and psychosocial needs. The information is to be used to: (1) determine if an applicant meets eligibility for entrance or retention in an assisted living facility; (2) if admitted, determine the appropriate level of care for the resident and develop a service agreement; and (3) update service needs and the service agreement		
3225.0	**Assisted Living Facilities**		

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3225.11.0	Resident Assessment		
3225.11.2 S/S – D	**A resident seeking entrance shall have an initial UAI-based resident assessment completed by a registered nurse (RN) acting on behalf of the assisted living facility no more than 30 days prior to admission. In all cases, the assessment shall be completed prior to admission. Such assessment shall be reviewed by an RN within 30 days after admission and, if appropriate, revised. If the resident requires specialized medical, therapeutic, nursing services, or assistive technology, that component of the assessment must be performed by personnel qualified in that specialty area.** **This requirement was not met as evidenced by:**	1. R1's UAI, elopement risk assessment, and service plan were updated by Health Services Director (HSD) (RN) on 2/21/2026 to reflect diagnoses of dementia with hallucinations and identified elopement risk. R1 received a psychiatric evaluation on 2/19/2026, and was placed on 1:1 supervision on 2/18/2026, and transitioned to a Secured Memory Care on 2/28/26.	2/28/2026
	Based on record review and interview, it was determined that for one (R1) out of four residents reviewed for elopement risk, the facility failed to ensure that R1's initial UAI captured the resident's risk for elopement and a diagnosis of visual hallucinations. Findings include: Review of R1's record revealed:	2. All residents have the potential to be affected by this deficient practice, all residents had elopement assessments completed by HSD by 2/10/2026 to determine elopement risk. In addition, all potential residents will continue to receive a UAI completed by an RN prior to admission to determine appropriateness for admission.	2/10/2026 and ongoing
	8/31/25 – R1's previous out of state skilled nursing facility completed the form entitled "The Resident Health Assessment for Assisted Living Facilities." Under Section 1. Health Assessment, the facility checked "Yes" for elopement risk. In addition to the 8/31/25 document, the previous out of state skilled nursing facility provided progress notes and therapy notes regarding R1, specifically:	3. Facility will continue to ensure the following changes to the admission process immediate and on-going. • Admission Review Process: All pre-admission documentation must be reviewed by the HSD/RN prior to admission to ensure appropriate placement per	2/10/2026 and ongoing

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	-8/15/25 2:32 PM – Psych progress note documented, "... [R1] states he does take Seroquel at home voicing that he sees things that sometimes he questions if they're real or not... Assessment/Plan... Visual hallucinations. Will continue to monitor for improvement or worsening of the following signs and symptoms of psychosis: hallucinations...". -8/26/25 10:35 AM – Physical Therapy treatment encounter note documented, "... Precaution Details: visual hallucinations... Confusion with known dementia...". 9/12/25 – The facility's elopement risk screening tool completed by E3 (HSD of the Memory Care Unit) documented a score of 10, which indicated that R1 was at risk for elopement. 9/18/25 – R1 was admitted to the assisted living facility. 9/18/25 – The initial UAI assessment, dated 9/8/25, by E3 documented that R1 had a diagnosis of dementia, a long-term memory problem and no history of wandering or other behaviors. The initial UAI assessment lacked evidence that R1 had a diagnosis of visual hallucinations and was at risk for elopement. 2/26/26 5:30 PM – Finding was reviewed during the exit conference with E1 (ED) and E2 (HSD).	Delaware regulations. • UAI Compliance Process: UAI assessments will be completed: o Prior to admission o Within 30 days post-admission o Annually o With any significant change in condition • Elopement Risk Identification: A standardized elopement risk assessment tool is required: o On admission o Quarterly o With change in condition 4. The HSD/ED and/or Designee will audit: • 5 resident charts weekly x 4 weeks, then • Bi-weekly x 2 months, then • Monthly x 1 month Audits will ensure: • UAI accuracy • Elopement risk identification • Service plan alignment Compliance goal: 100% Results will be reviewed in QAPI. Any non-compliance will result in immediate corrective action and re-education.	5/1/2026 and ongoing
3225.11.5 S/S- D	**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**		

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	and when there is a significant change in the resident's condition. **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for one (R1) out of four residents reviewed for elopement risk, the facility failed to ensure that R1's UAI assessment was updated with a change in condition to reflect R1's increase in hallucinations in November 2025. Findings include:	1. R1's UAI, elopement risk assessment, and service plan were updated by HSD on 2/21/2026 to reflect diagnoses of dementia with hallucinations and identified elopement risk. HSD reviewed service plan updates for R1 with front line staff on 2/19/2026 to ensure resident's care needs were continued to be met.	2/21/2026
	Review of R1's record revealed: 11/18/25 1:46 PM – A encounter progress note by C2 (contracted NP) documented that R1 was seen for "c/o [complaint of] hallucinations... Patient reports experiencing episodes of hallucinations intermittently. He states the hallucinations predominantly involve vivid and distressing scenes, such as perceiving a fire outside when there was none. These hallucinations occur sporadically and are not a daily occurrence, with the most recent episode occurring last week. The patient acknowledges the experience as unsettling but states an ability to recognize when the hallucinations are not real. He states he will stop and close his eyes for a few minutes and then the hallucinations will 'go away'. He asked if he was getting 'enough' medication for my hallucinations... Will refer to... psychiatry for an evaluation... Discussed the plan of care with the staff nurse... Assessment and Plan: Acute Hallucinations... Coordination with psychiatric services has been initiated to evaluate current treatment and medication... Monitor fre-	2. A facility wide audit was completed by the HSD to ensure all residents with a change of condition had Updated UAI assessment and Revised Service Plans.	2/10/2026
		3. Change in condition protocol implemented. Staff are required to report changes in condition to include but not limited to; hallucinations, behavior changes, elopement attempts. The HSD RN will review reported changes within 24 hours, update UAI and Service Plan as indicated. Provider communication process: all external documentation log upon receipt, reviewed within 24 hours and incorporated into resident service plan. All staff members will receive	5/8/2026

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	quency and context of hallucinations and report any increase in distress or functional impairment...".	re-education and training on reporting change of condition to the registered nurse.	
	11/25/25 4:17 PM – An initial psychiatric evaluation note by C3 (contracted NP) documented that R1 "reports experiencing visual hallucinations intermittently... Biological factors include age-related cognitive decline and dementia, contributing to diminished insight and judgment, as well as presenting with psychotic symptoms such as visual hallucinations... Plan: 1. Major Neurocognitive Disorder (Dementia)... Continue quetiapine 50 mg at bedtime... Recommendations: Focus on continuous monitoring of cognitive function and behavior changes. Goals include ensuring safety... Coordination with facility staff for ongoing cognitive assessments and possible involvement in specialized dementia programs... 4. Psychotic Symptoms – Visual Hallucinations... Continue to monitor for recurrence and potential triggers of hallucinations... All recommendations have (sic) been... communicated with the... community staff...". The facility failed to update the UAI assessment when R1's had a change in condition that required psychiatric evaluation and monitoring for an increase in hallucinations. 2/26/26 5:30 PM – Finding was reviewed during the exit conference with E1 (ED) and E2 (HSD).	4. The HSD will ensure Weekly audits occur for progress notes and UAI updates. In addition, this will be reviewed during the weekly Interdisciplinary Team Meetings (IDT). Monthly Quality Assurance Process Improvement (QAPI) meetings will be held to review progress, identify trends and opportunities for areas of improvement. The Executive Director (ED) will ensure that any areas of deficiency identified will be addressed with a process improvement plan to achieve a Compliance Goal of 100%.	5/8/2026 and ongoing
3225.19.0	**Records and Reports**		
3225.19.6	**Reportable Incidents shall be reported immediately, which shall be within 8 hours of**		

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	the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.		
3225.19.7	**Reportable incidents include:**	3225.19.7	
3225.19.7.5	**Resident Elopement.**		
3225.19.7.5.2 S/S = D	**Any circumstance in which a cognitively impaired resident, whose whereabouts are unknown to staff, exits the facility.** **This requirement was not met as evidenced by:** Based on observation, record review and interview, it was determined that for one (R1) out of four residents reviewed for elopement risk, the facility failed to report R1's three elopements to the State Agency within the required eight hours. Findings include: Cross refer to 16 Del. C. Chapter 11, Subchapter III, § 1131 (12) a. Review of R1's record, facility surveillance video and interview of facility staff revealed the following three elopements were either not reported to the State Agency or not reported within the required 8-hour timeframe: 2/12/26 8:18 PM – R1 exited the front entrance without staff knowledge. E12 had to unlock the front door to let him back into the facility. E12 notified E10 (LPN) that R1 wanted to leave. This elopement was not reported to the State Agency. 2/16/26 4:58 AM – R1 exited the front entrance without staff knowledge. An unknown staff member had to unlock the front door to let him back into the facility. This	1. R1's UAI and service plan were updated on 2/21/2026 to reflect exit seeking behavioral changes. R1's UAI, elopement risk assessment, and service plan were updated by Health Services Director (HSD) (RN) on 2/21/2026 to reflect diagnoses of dementia with hallucinations and identified elopement risk. R1 received a psychiatric evaluation on 2/19/2026 and was placed on 1:1 supervision on 2/18/2026, and transitioned to a Secured Memory Care on 2/28/26. Upon resident's move to the secured memory care unit there were no other reportable events identified for elopements. 2. All residents have the potential to be affected by this deficient practice. All resident incidents are reported to the HSD when they occur. The incident is documented and the HSD ensures appropriate follow-up to meet the residents care needs. Incident reports are reviewed by the HSD and ED to ensure proper reporting to the state agency occurs timely. In addition, interventions are put in place and	2/28/2026 5/8/2026

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	elopement was not reported to the State Agency. 2/18/26 8:34 PM – R1 exited the front entrance without staff knowledge. An unknown bystander driving on South Harmony Road stopped at the facility to notify nursing staff that R1 was outside. The facility reported this elopement on 2/19/26 at 3:13 PM, approximately 18 hours later. 2/26/26 5:30 PM – Finding was reviewed during the exit conference with E1 (ED) and E2 (HSD).	the service plans is updated when appropriate to ensure safety. Lastly, staff members are trained on any resident change of condition. In addition, interventions are implemented, and the service plans are updated, as appropriate, to ensure resident safety. Lastly, staff are trained to recognize and report any changes in a resident's condition. Staff have also received training on reportable events and required reporting timelines.	
16 Del. C. Chapter 11, Subchapter III, **§ 1131 Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents.** **S/S – K**	**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 observation, interview, review of record and other documentation as indicated, it was determined that for one (R1) out of four residents reviewed for elopement risk, the facility failed to provide a safe environment when R1, a resident with diagnoses of dementia with increased hallucinations and paranoia, exited the facility without staff knowledge four (4) times: 2/12/26 at 8:18 PM, 2/15/26 at 11:30 PM, 2/16/26 at 4:57 AM and 2/18/26 at 8:34 PM. On 2/18/26, R1 was outside without staff knowledge for approximately 21 minutes	3. All staff, including the ED and HSD will receive training on reportable events. All resident incidents are reported to the HSD when they occur. The incident is documented and the HSD ensures appropriate follow-up to meet the residents care needs. Incident reports are reviewed by the HSD and ED to ensure proper reporting to the state agency occurs timely. In addition, interventions are put in place and the service plans is updated when appropriate to ensure safety. Lastly, staff members are trained to any resident care need change. In addition, interventions are implemented and the service plans are updated, as appropriate, to ensure resident safety. Lastly, staff are trained to recognize and report any changes in a resident's	5/8/2026

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	until an unknown bystander notified nursing staff that R1 was outside. R1 was found in the middle of South Harmony Road, a busy roadway. An immediate jeopardy was called on 2/26/26 at 2:52 PM. The facility abated immediate jeopardy as of 3/4/26 at 4:00 PM. Findings include: Review of R1's record revealed: 8/31/25 – R1's previous out of state skilled nursing facility completed the form entitled "The Resident Health Assessment for Assisted Living Facilities." Under Section 1. Health Assessment, the facility checked "Yes" for elopement risk. In addition to the 8/31/25 document, the previous out of state skilled nursing facility provided progress notes and therapy notes regarding R1, specifically: -8/15/25 2:32 PM – Psych progress note documented, "... [R1] states he does take Seroquel at home voicing that he sees things that sometimes he questions if they're real or not... Assessment/Plan... Visual hallucinations. Will continue to monitor for improvement or worsening of the following signs and symptoms of psychosis: hallucinations...". -8/26/25 10:35 AM – Physical Therapy treatment encounter note documented, "... Precaution Details: visual hallucinations... Confusion with known dementia...". 9/12/25 – The facility's elopement risk screening tool completed by E3 (HSD/RN of the Memory Care Unit) documented a score of 10, which indicated that R1 was at risk for	condition. Weekly all resident incidents are reviewed at IDT Meeting to ensure follow-up and proper reporting has occurred. 4. Staff have been retrained to report all incidents to the HSD/ED or Designee upon occurrence. The HSD/ED or Designee will determine if the incident is a reportable event. In addition, the HSD and ED will review incident reports on a daily basis to ensure proper reporting has occurred. Weekly, all incidents will be reviewed in the IDT meeting to determine that reportable events have the required follow-up. Monthly a QAPI meeting is held to review all incident reports and reportable events to determine trends for further Root Cause Analysis and Improvement plans. All Staff members are trained upon hire, yearly, and needed on the reportable events requirements as defined by the State.	5/8/2026

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	elopement. The screening tool's instructions stated, "... If the total score is 10 or greater, the resident should be at risk for elopement. Prevention protocols should be followed and documented on the service plan." 9/12/25 – The facility's BIMS (Brief Interview for Mental Status) evaluation tool by E3 documented that R1 had a moderate cognitive impairment. 9/18/25 – R1 was admitted to the facility. 9/18/25 – The initial UAI assessment by E3 documented that R1 had a diagnosis of dementia, a long-term memory problem and no history of wandering or other behaviors. The initial UAI and Service Plan lacked evidence that R1 had a diagnosis of visual hallucinations and was at risk for elopement. 9/30/25 – A new patient encounter note by C1 (contracted Medical Doctor) and C2 (contracted NP) via telehealth documented that R1 had a history of dementia, mood disturbances, anxiety, major depressive disorder... hallucinations and repeated falls... relocated from [name of another State] ... found to be pleasantly confused. He occasionally thought he was in [name of another State], and periodically going off on tangents during conversations... He ambulates with a rolling walker and a shuffling gait... Staff deny any behavioral concerns. Will Monitor... Assessment and Plan: 1... Dementia and Cognitive Deficits... Recommendations: Regular monitoring of cognitive status... 16. Visual Hallucinations... Possible related to dementia; assess for triggering factors. Medications: Quetiapine 50mg QHS [every	**16 Del. C. Chapter 11, Subchapter III,** 1. R1 was placed on one hour safety checks on 2/16/2026. R1 placed on 1:1 supervision on 2/18/2026. Psychiatric Evaluation was completed on 2/19/2026. Service Plan updated on 2/19/2026. R1 transferred to secured memory care unit on 2/28/2026. IJ was abated on 3/4/2026. 2. All Residents have the potential to be affected by this deficient practice. All residents were evaluated for elopement risk by 2/10/2026 by the HSD. UAI assessments completed by HSD for all residents deemed to be an elopement risk. Residents identified to be a possible elopement risk were reassessed and interventions put in place including but not limited to a transition to the secured memory care unit. Transitions were completed on 3/16/2026. 3. Facility implemented an Elopement Prevention Plan. This plan included re-training of all staff on risk identification, staff response protocol, and immediate response to door alarms. Staff were trained	3/4/2026 3/16/2026 3/4/2026 and ongoing

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	bedtime] Recommendations: Comprehensive neurological and psychiatric evaluation to determine underlying cause, ensure safety measures...". 10/10/25 – The 30-day UAI assessment by E13 (RN) documented that R1 needed supervision for mobility, used a walker, had no problem with long-term memory and no history of wandering or behaviors. 10/10/25 – The Service Plan was updated to reflect that R1 was able to ambulate independently with a walker and was cognitively impaired. The 30-day UAI and Service Plan lacked evidence that R1 had a diagnosis of visual hallucinations and was at risk for elopement. 11/18/25 1:46 PM – A encounter progress note by C2 (contracted NP) documented that R1 was seen for "c/o [complaint of] hallucinations... Patient reports experiencing episodes of hallucinations intermittently. He states the hallucinations predominantly involve vivid and distressing scenes, such as perceiving a fire outside when there was none. These hallucinations occur sporadically and are not a daily occurrence, with the most recent episode occurring last week. The patient acknowledges the experience as unsettling but states an ability to recognize when the hallucinations are not real. He states he will stop and close his eyes for a few minutes and then the hallucinations will 'go away'. He asked if he was getting 'enough' medication for my hallucinations... Will refer to... psychiatry for an evaluation... Discussed the plan of care with the staff	on monitoring exits and reporting procedures. Trainings were provided by the HSD on several dates in February 2026. On 3/4/2026 the IJ was abated. The Facilities Director (FD) has continued to monitor all exit doors to ensure the alarm continues to function properly. 4. All potential residents continue to receive an initial UAI based resident assessment by the HSD to determine appropriateness for Assisted Living. In addition, the HSD continues to complete the UAI based assessment at change of condition and every 6 months. All staff are trained upon hire on elopement prevention and yearly and as needed. Staff have been trained to alert the HSD/ED or Designee of any changes of condition including but not limited to exit seeking behavior immediately. Incident reports are reviewed daily the HSD and ED for follow-up and needed interventions and updates to service plans. Weekly: Residents care needs including changes of conditions are reviewed weekly at the IDT meeting to ensure residents care needs have been met and further interventions	5/8/2026 and ongoing

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	nurse... Assessment and Plan: Acute Hallucinations... Coordination with psychiatric services has been initiated to evaluate current treatment and medication... Monitor frequency and context of hallucinations and report any increase in distress or functional impairment...". 11/25/25 4:17 PM – An initial psychiatric evaluation note by C3 (contracted NP) documented that R1 "reports experiencing visual hallucinations intermittently... Biological factors include age-related cognitive decline and dementia, contributing to diminished insight and judgment, as well as presenting with psychotic symptoms such as visual hallucinations... Plan: 1. Major Neurocognitive Disorder (Dementia)... Continue quetiapine 50 mg at bedtime... Recommendations: Focus on continuous monitoring of cognitive function and behavior changes. Goals include ensuring safety... Coordination with facility staff for ongoing cognitive assessments and possible involvement in specialized dementia programs... 4. Psychotic Symptoms – Visual Hallucinations... Continue to monitor for recurrence and potential triggers of hallucinations... All recommendations have been... communicated with the... community staff...". The facility failed to update R1's UAI assessment and service plan with a change in condition that required psychiatric evaluation and monitoring for an increase in hallucinations.	and education occurs. Facility Director (FD) will ensure that all exit doors and alarms are in proper working order. Monthly: Trends are reviewed during QAPI meeting. This meeting includes a Root Cause Analysis for those trends identified and improvement plans are put in place to ensure resident safety.	

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	12/30/25 3:27 PM – The psychiatric follow up evaluation by C3 (contracted NP) documented a "... mental status exam... Mood: Described as 'fine,'... Thought Content: Denies current hallucinations, although has had recent visual ones. Insight: Limited, due to cognitive decline and incomplete awareness of his condition. Judgement: Impaired, secondary to cognitive limitations from dementia...". 1/14/26 2:36 PM – A psychiatric follow up evaluation note by C3 (contracted NP) documented, "... The patient reports increased hallucinations and paranoia since the last visit, with specific delusional thoughts that included believing someone announced via an intercom that his son has a gun, and a subsequent belief that the kitchen staff is suing him. He also experienced a delusion that his apartment was being flooded, although he observed no water upon investigation... There has been adherence to his medication regimen, specifically quetiapine, though the recent increase was met with fatigue and confusion, leading... to request a return to the previous dose... Since the last visit, there appears to be continued presence of hallucinations and paranoia despite medication, with no significant improvement in symptom control. This suggests a need for ongoing adjustment of treatment strategies. Symptom severity shows fluctuation with delusional severity impacting daily judgment and insight... Plan... Paranoid Delusions... Past improvements have been noted but recent exacerbations reveal inadequately controlled paranoia...".		

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	1/27/26 – The facility's SLUMS cognitive evaluation form documented that R1 scored a 9 out of 30, which revealed that he had a severe cognitive impairment. 2/12/26 3:15 PM – A nurse's note by E4 (LPN) documented, "Resident noted with increased confusion and hallucinations... NP [name] notified, UA [urinalysis]... order received... Staff continues to monitor...". Elopement #1 2/12/26 8:18 PM – R1's elopement from the facility on this date and time was uncovered during facility staff interviews with State Agency staff during the survey and confirmed by viewing the facility's surveillance video. Observation by State Agency staff on 2/25/26 at 2:24 PM of the surveillance video revealed that on 2/12/26 at 8:18 PM, R1 exited the front door entrance without a walker. R1 continued to walk but stayed under the porch area and was waving his hands and arms across and then up and down toward South Harmony Road. R1 then turned, walked back and opened the outside door of the front entrance at 8:20 PM. Staff interview revealed that a staff member had to let R1 in by entering the door code for the locked inside door of the front entrance. Elopement #2 2/15/26 11:30 PM – The facility reported to the State Agency, "... while staff was conducting rounds the front door alarm started going off resident in room [number] exited the building without his walker and proceeded to walk outside. Staff observed the		

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	resident walking along the exterior walkway. Resident exited the lock door and the outside door. He walked about 10-15 feet away from the door. Resident was able to be redirected back to facility without incident. Resident last seen at 11:15 doing rounds when staff assisted him to bed residence (sic) stated that he was attempting to go home." In response to this elopement, the facility reported to the State Agency that they took following actions: - R1 was assessed as alert with confusion, vitals within normal limits and no injury or pain; - Urinalysis was collected on 2/15/25 with results pending; - Obtained physician order for additional one-time dose of Seroquel; and - R1 placed under observation and close monitoring. It should be noted that the R1's urine sample was received by the lab on 2/14/26 and negative result was reported on 2/15/26. 2/16/26 1:30 AM – The February 2026 MAR (Medication Administration Record) revealed that R1 was administered a one-time dose of Seroquel 25mg for increased agitation. 2/16/26 4:19 AM – A progress note by E4 (LPN) documented, "Received a call back from on call [name] NP @ 0045 [12:45 AM], One time order to give resident Seroquel 25		

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	mg for agitation, medication was administered with effective results. Resident observed sleeping in bed at around 0130 (1:30 AM), hourly safety checks initiated and maintained...". Elopement #3 2/16/26 4:57 AM – R1's elopement from the facility on this date and time was uncovered during facility staff interviews with State Agency staff during the survey and confirmed by viewing the facility's surveillance video. The facility's surveillance video captured R1 exit the front entrance at 4:57 AM, walked to the circle driveway, turned around, walked back to the front entrance and opened the outside door and entered at 4:58 AM. Staff interview revealed that a staff member had to let R1 in by entering the door code for the locked inside door of the front entrance. 2/16/26 untimed – The Elopement Risk Evaluation form documented that R1's score was a 20, which revealed that he was a moderate risk. 2/16/26 12:10 PM – An email communication to C2 (contracted NP) from E2 (HSD) requesting for a "follow-up psychiatric evaluation for the resident due to an increase in hallucinations and recent elopement behaviors...". 2/16/26 12:57 PM – A progress note by E2 (HSD) documented that R1's care plan had the following added: "Safety: Elopement Risk close monitoring of resident".		

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	2/18/26 1:36 PM – A psychiatric follow up evaluation by C3 (contracted NP) documented, "... Hallucinations and delusions with elopement attempts. Staff requested psychiatric evaluation due to increased hallucinations and delusions... During today's encounter, [R1's name] reported belief that 'someone is going to set the community on fire' and stated intent to break a window if needed to escape. Facility collateral (sic) indicated he was observed around 4:00 AM attempting to leave the community due to fear that it would be set on fire... Concentration and cognition were impaired consistent with known dementia... Psychotic symptoms were present, including paranoid delusional belief regarding imminent arson and associated fear-driven behavior; hallucinations were reported by staff... safety risk is elevated for accidental harm due to impaired judgement, paranoia, attempted elopement, and stated intent to break a window. Risk factors: dementia, psychosis/paranoia, nocturnal agitation, elopement behavior, impaired judgment. Protective factors: supervised care environment, staff involvement, treatment engagement, planned transfer to high-support setting... Plan... recommend move to locked memory care unit for enhanced supervision and safety... nighttime safety plan (increased checks, door alarms as appropriate)...". 2/18/26 4:17 PM – A progress note by E2 (HSD/RN) documented, "HSD spoke with resident regarding his safety and exiting the building without staff knowledge. Resident informed that the behavior is unsafe, and		

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	the risks involved. Also spoke to R1's POA regarding residents' safety. Per conversation resident and R1's POA expresses safety concern and are interested in memory care. Tour scheduled for Friday at 1 PM." Elopement #4 2/18/26 8:45 PM – The facility reported to the State Agency, "8:45- 9:00pm a passerby arrived to the facility, he notified staff that there is an elderly man outside. He then requested to see the nurse. Nurse and medtech (sic) noted resident [room number] outside of facility near the road. Resident was last seen in his room at 8 pm after receiving his bedtime medication." In response to elopement #4, the facility reported to the State Agency that they took following actions: - R1 was brought back into the facility without confrontation; - R1 was assessed with no injury and denied pain; - R1 was placed under 1:1 supervision currently using facility staff; - R1's family consented to emergency transfer if needed to support resident; and - R1's family providing 1:1 care through agency 24 hours/7 days effective 2/19/26 at 8:00 PM. 2/19/26 8:14 AM – A progress note by E2 (HSD/RN) documented, "HSD completed a follow-up assessment regarding the recent elopement. Resident was observed in his		

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	room sitting on the bed with the 1:1 caregiver present. Resident provided his account of leaving the facility. He stated he heard a group of people in wheelchairs speaking in a foreign language and believed they were plotting to burn down the facility. He further reported that the wheelchairs were moving on their own. Resident stated he attempted to go outside to flag down a car to contact police and fire services. He also reported seeing five-gallon bottles of gasoline buried under a bench outside his window, which he believed were intended to blow up the facility. Resident was reoriented to reality and reassured regarding safety. He was informed that there is no identified threat and that staff are present to assist and support him. Resident verbalized understanding that staff are available to help; however, he continues to express belief in his perceptions and questioned staff involvement." 2/19/26 – The Elopement Risk Evaluation form documented that R1's score was a 28, which revealed that he was a high risk. 2/24/26 1:15 PM – During a combined interview, E6 (Maintenance Director) and E5 (MT) explained that anyone can go outside of the facility at any time, day or night. The receptionist hours are 8 AM to 8 PM. When the receptionist leaves, the inside front door was locked so that no one can enter the facility from 8:00 PM to 8:00 AM, unless they enter the security code. The outside front door does not lock. 2/24/26 1:26 PM – At the time of this observation of the facility's surveillance videos		

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	with E5 (MT) and State Agency staff revealed the following three elopements: -Elopement #2: 2/15/26 at 11:32 PM; – R1 exited the front entrance, slowly walking under the porch area without his walker. E4 (nurse) and two caregivers exited the front door and escorted R1 back into the facility at 11:34 PM. -Elopement #3: 2/16/26 at 4:57 AM – R1 exited the front entrance without his walker. R1 walked to the circle driveway, turned around, walked back and entered in the outside front entrance door at 4:58 AM. -Elopement #4: 2/18/26 at 8:34 PM – R1 exited the front entrance without his walker. R1 turned right and walked under the porch area. At 8:38 PM, R1 walked back towards the front door and proceeded to walk towards the circle driveway waving his hands towards South Harmony Road. At 8:40 PM, R1 walked across the circle driveway to the other side. At 8:42 PM, R1 was observed standing under a streetlight before the snow-covered grass waving and raising his arms towards the road. At 8:45 PM, R1 standing in the same position, under the light, and waving his arms. From 8:46 PM to 8:48 PM, R1 walked to his left and stepped up on the curb and proceeded to walk across the grass lawn, with snow, towards South Harmony Road, a busy roadway. At 8:49 AM, an unknown driver pulled up to the front of the facility and ran to the facility's front entrance. At 8:50 PM, R1 was not visible on the surveillance camera. At 8:50 PM, the unknown driver was observed walking from the facility's front entrance toward the road across the circle driveway under		

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	the light. At 8:51 PM, the unknown driver ran back to the facility's front entrance. At 8:53 PM, a nurse and two caregivers come out of the facility's front entrance. At 8:55 PM, R1 was escorted back into the facility by the nurse and caregiver. The unknown driver left in his vehicle. 2/24/26 1:55 PM – During an interview, E5 (MT) reviewed and confirmed that the surveillance video timeclock was one hour behind. Surveillance video times were adjusted to reflect the actual times of each elopement in this State Report. 2/25/26 9:40 AM – During an interview, E4 (LPN) confirmed that she arrived to work on Sunday, 2/15/26, at 11:20 PM and was talking to the caregivers upstairs on the second floor. E4 stated that around 11:30 PM, the front door alarm was going off and everyone on 11 PM-7AM shift all came downstairs. E4 stated that we went outside and found him on the porch just standing there. E4 stated that R1 said he was going home. E4 stated that she brought him up to the second-floor nurse's station as he was "a little shaky, not agitated." E4 stated that she placed R1 back in bed around midnight and the assigned caregiver, E7, stayed outside his room on the chair and initiated one-hour checks. E4 stated that she called the HSD (E2) and the doctor because R1 was "a little shaky, going home and walked out." E4 stated that an order was received from the on-call provider for a one-time dose of Seroquel. Medication was administered between 1-1:30 AM. E4 stated that R1 went to sleep but then he would wake up and come to his door. E4		

DELAWARE HEALTH AND SOCIAL SERVICES

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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: The Pointe at South Harmony Place

DATE SURVEY COMPLETED: March 12, 2026

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	stated that around 4ish, R1 was walking toward the front door. The caregiver was closely watching the resident, but he was not on 1:1 yet. E4 stated that all 7-3 AM staff were made aware that R1 was on one-hour checks and that he walked out of the facility. E4 stated that R1 was having delusions and hallucinations and getting worse. E4 stated a urinalysis was ordered on 2/12/25, but it was negative. 2/25/26 10:10 AM – During an interview, E7 (Caregiver) confirmed that R1's first attempt to exit the building was 11:30 AM on Sunday, 2/15/26, and she was in the nurse's station. E7 stated we (staff) all ran as he was outside the building. E7 stated that R1 "attempted a second time", but she could not remember the exact time. E7 the door alarm went off and he was between the (locked) inside door and the outside door of the front entrance. When we brought him inside and had a wheelchair after the second time, E7 stated that R1 made a sound like a horse and started running down the hall to his room. E7 stated that we all went behind him, R1 went into his room. E7 stated he wasn't calm and peaceful. E7 said she sat down in the chair outside of his room until my next resident called. E7 stated that the nurse (E4) gave him some medication. E7 stated that she checked him every hour by opening his door. E7 stated that she was not on 1:1 with R1 during this shift. E7 stated that previous night, R1 would open his door, and he would say "Fire, Fire" when he would see a bright light or loud sounds at different times, and he would come out. I would sit on the couch outside and redirect him back to bed.		

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	2/25/26 10:56 AM – During an interview, E8 (Med Tech) stated that she was working 11 PM – 7 AM shift on 2/15/26 and was in the nurse's station when the door alarm went off. E8 stated that, "We all ran downstairs. I ran directly to his room and found him not there. I saw them coming in with him." E8 stated that "After some time, we were doing our rounds (every 2 hours). Again, we heard the bell (alarm) go off. I was in my section on the second floor doing rounds. [R1] was at the second [inside locked] door between the doors. I don't remember who let him in. This time he was agitated and literally ran towards his room and his words were not clear. I didn't know he could run without a walker." E8 stated that they all went down to his room, R1 went into his room and closed the door. The nurse went in and talked to him. This time his caregiver was to keep watch. 2/25/26 12:29 PM – During an interview, E9 (Receptionist) stated that on 2/12/26 R1 came to the front door at approximately 6:30 PM – 7:00 PM, walked out the two doors and she was able to redirect him back in the facility. E9 stated that R1 thought that she had a weapon on her by touching her pocket. E9 stated that she called E10 (LPN), who was not currently working, because she was worried that R1 would exit the facility after she left at 8 PM. E9 stated that E10 came into the facility on 2/12/26 in response to her call. 2/25/26 1:05 PM – During an interview, E12 (Caregiver) stated on 2/18/26 evening shift, she heard the door alarm, checked the front		

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	door and back door, and then silenced the alarm. E12 stated that she didn't go outside but checked inside. E12 stated that she reset the alarm before the unknown bystander came to the door. E12 stated that she was on break downstairs, saw the unknown bystander at the front door, and he said something about a resident. E12 stated that she called E10 (LPN) to come downstairs. E12 stated that the bystander said someone was outside the building and he was about to be in the road. E12 stated that they (E10, bystander and E12) ran to the resident and R1 was actually in the street without his walker and was confused. When asked about other elopements, E12 stated that she worked the evening shift 2/12/26, heard the door alarm and found R1 in between the two front entrance doors. E12 opened the locked door and brought R1 back inside the facility. E12 stated that R1 said he wanted to go out. 2/25/26 2:55 PM – During an interview, E10 (LPN) confirmed that E9 (Receptionist) called him about R1 on the evening of 2/12/26. E10 stated that E9 told him that R1 was trying to leave the facility and that R1 was going home. E10 stated by the time he got to the facility on 2/12/26, R1 was back in his room and answering questions appropriately. E10 asked the assigned Med Tech, E11, if she administered R1's medications and E11 responded no. E10 stated that he recommended that E11 give R1's medications and stayed in the facility until 7:30 PM. When asked about other elopements, E10 confirmed he worked on the evening shift of 2/18/26. E10 stated he was in the nurse's station and one of the caregivers called me		

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	about a man at the front door saying an elderly man was at the side of the road. E10 stated that he saw R1 waving his hands, and R1 said he wanted to go home. E10 stated that he never heard the alarm going off. 2/26/26 8:40 AM – During an interview, E2 (HSD/RN) stated that there were no other resident elopements since she started in November 2025. When asked if the facility uses a wander guard system, she replied "no". 2/26/26 11:00 AM – During an interview, E2 confirmed that she was not aware of the 2/12/26 incident where R1 exited the facility. 2/26/26 2:52 PM – An immediately jeopardy was called in the presence of E1 (ED) and E2 (HSD). In response to the immediate jeopardy, the facility's abatement plan included all of corrective actions listed below: -2/12/26 – Urinalysis ordered. (2/14/26 negative results) -2/16/26 12:00 AM – R1 placed on one hour safety checks. -2/16/26 4:19 AM – Received order for one-time dose of Seroquel 25mg for agitation. -2/16/26 12:10 PM – Requested a follow-up psychiatric evaluation. (Conducted on 2/18/26 at 1:36 PM) -2/18/26 10:00 PM – 1:1 supervision Initiated.		

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	-2/19/26 11:17 AM – Facility communicated with R1's POA about a safety plan and coordination of 1:1 supervision going forward. -2/19/26 – Maintenance conducted safety checks on all doors. -2/20/26 – In-service with some staff regarding the facility's door alarms. -2/25/26 – In-service with some staff regarding elopements and prevention. -3/4/26 – HSD will complete door education in-service for all employees. -3/4/26 – HSD will complete elopement drill and in-service to ensure all employees have been educated. -3/4/26 – HSD will complete notification in-service with all staff to ensure all employees are made aware on when to notify HSD. 2/26/26 5:30 PM – Finding was reviewed during the exit conference with E1 (ED) and E2 (HSD/RN). 3/12/26 10:30 AM – An unannounced follow-up visit to the facility verified the facility's abatement of the immediate jeopardy based on staff interviews and record review of the corrective actions.		

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