



**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:** Harmony at Glasgow

**DATE SURVEY COMPLETED:** April 1, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	<p>An unannounced Complaint Survey was conducted at this facility from March 31, 2026, through April 1, 2026. The deficiencies contained in this report are based on observations, interviews, review of resident's clinical records, and review of other facility documents as indicated. The facility census on the first day of the survey was seventy - seven. The survey sample totaled seven residents.</p> <p>Abbreviations/definitions used in this report are as follows:</p> <p>ED - Executive Director; HD - Healthcare Director; LPN - Licensed Practical Nurse; MT - Medication Technician; POA – Power of Attorney; PCP – Primary Care Provider; RN - Registered Nurse; RA – Resident Assistant;</p>		
3225.0	<b>Assisted Living Facilities</b>		
3225.16.0	<b>Staffing</b>		
3225.16.2	<b>A staff of persons sufficient in number and adequately trained, certified, or licensed to meet the requirements of the residents shall be employed and shall comply with applicable state laws and regulations.</b>	3225.16.2	4/24/26
S/S – D	<p>Per the State of Delaware Board of Nursing's Scope of Practice document entitled "RN, LPN, and NA/UAP Duties 2024", last revised 4/10/24, only a Registered Nurse (RN) can</p>	<p>A- RN secured to assess all resident falls. Resident R5 continues to reside in the community with no negative outcome identified. B- All residents have the potential to be affected. C- Upon internal review, it was determined that an assessment was not completed by an RN due to E4 not notifying the on-call RN of R5's fall. As a result, education will be provided, by Executive Director/designee, to all RNs and LPNs employed by the community</p>	

Provider's Signature *[Signature]*

Title EXECUTIVE DIRECTOR Date 4/17/26



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	<p><b>perform post fall assessment and documentation.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on record review and interviews, it was determined that for one (R5) out of three residents reviewed for falls the facility failed to ensure that the initial post fall assessment was completed by a registered nurse. Findings include:</p> <p>Review of R5's clinical record revealed:</p> <p>11/30/25 8:00 PM – A facility incident report completed by E4 (LPN) documented that R5 experienced a witnessed fall with no injury. Review of the incident report lacked evidence that a registered nurse assessed R5 after the fall.</p> <p>12/1/25 4:52 AM – A progress note written by E4 (LPN) in R5's clinical record documented, "Care partner was giving resident a shower this evening and after he was done care partner was assisting him out of the shower when his left leg "gave out" and care partner had to lower him to the floor in the shower. [E4 (LPN)] was called to come and examine resident. Resident was sitting on his bottom in the shower upon assessment...POA, PCP, ED and HD were notified."</p> <p>3/31/26 1:26 PM – During an interview E4 (LPN) was unable to recall which RN assessed R5 after the fall on 11/30/25. E4 stated, "It may have been [E2 (HD)] but I remember he did not have an injury and he declined to the hospital."</p>	<p>that the Healthcare Director must be notified as identified in the Fall Management Policy.</p> <p>D- The Healthcare Director / designee will audit recent fall assessments to ensure compliance. Once this is achieved, the Healthcare Director/designee will conduct an audit 1 month later and if 100% compliance is achieved, the community will conclude that the deficient practice has been corrected. Fall assessment audits will be reviewed quarterly at QA during the evaluation period.</p>	

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<p>3225.19.0</p> <p>3225.19.6</p> <p>S/S - D</p>	<p>3/31/26 1:53 PM – During an interview E2 (HD) confirmed the finding and that she did not assess R5 after the fall on 11/30/26. E2 stated, "I just spoke with [E8 (RN)] she was the RN covering and she confirmed she didn't complete an assessment."</p> <p>4/1/26 1:30 PM – Findings were reviewed with E1 (NHA) and E2 (HD) during the exit conference.</p> <p><b>Records and reports</b></p> <p><b>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.</b></p> <p><b>This requirement was not met as evidenced by:</b></p> <p>Based on record review and interview it was determined that for one (R3) out of three residents reviewed with reportable incidents, the facility failed to immediately report an allegation of abuse. Findings include:</p> <p>The facility policy on abuse last updated September 2025 indicated, "Reporting: Allegations of abuse, neglect, exploitations, mistreatment, injuries of unknown origin and/or misappropriation of resident property will be reported immediately to the State/local licensing board or any agency and other authorities as required by law."</p> <p>Review of R3's clinical record revealed;</p> <p>12/22/25 8:03 PM – The facility reported an allegation of staff to resident verbal abuse</p>	<p>3225.19.6</p> <p>A-Staff in-serviced on expectations of reporting abuse by Executive Director/designee. Resident R3 continues to reside in the community with no negative outcome identified in relation to the deficient practice.</p> <p>B- All residents have the potential to be affected.</p> <p>C- Education will be provided to all staff regarding abuse and reporting upon hire and annually to ensure compliance, by Executive Director/designee.</p> <p>D- The Healthcare Director/designee will review reportable incidents weekly to ensure that those incidents were reported timely and accurately. Once this is achieved, the Healthcare Director/designee will conduct an audit 1 month later and if 100% compliance is achieved, the community will conclude the deficient practice has been corrected. The reportable incident audits will be reviewed quarterly at QA during the evaluation period.</p>	<p>4/24/26</p>

Provider's Signature

*[Handwritten Signature]*

Title

EXECUTIVE DIRECTOR

Date

4/12/26



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<p>16 Del. Code §1131</p> <p>Chapter 11, Sub- chapter III.3</p> <p>Abuse, Neglect, Mistreat- ment, Fi- nancial Exploita- tion, of Residents or Pa- tients</p> <p>S/S- D</p>	<p>that occurred on 12/21/25 at 9:45 AM be- tween E4 (LPN) and R5.</p> <p>3/31/26 1:53 PM – During an interview E2(HD) confirmed that the report was not im- mediately reported. E2 stated, “[E3 (former ED) began the investigation the same day then I came in and told them to report it.”</p> <p>4/1/26 10:47 AM – During an interview E3 (former ED) confirmed that she was aware of the allegation of staff to resident abuse “im- mediately” on 12/21/25. E3 was unable to re- call a delay in reporting.</p> <p>4/1/26 1:30 PM – Findings were reviewed with E1 (NHA) and E2 (HD) during the exit conference.</p> <p><b>(12) “Neglect” means the failure to provide goods and services necessary to avoid phys- ical harm, mental anguish, or mental ill- ness.”</b></p> <p><b>This requirement was not met as evidenced by:</b></p> <p>Based on record review and interviews it was determined that for one (R3) out of three res- idents reviewed for abuse the facility failed to immediately remove an accused staff mem- ber to protect residents and prevent poten- tial further abuse. Findings include:</p> <p>The facility policy on abuse last updated Sep- tember 2025 indicated, “Procedures: Imme- diately remove the alleged perpetrator. Team members accused of abuse or neglect will be placed on administrative leave and must leave the community immediately.”</p>	<p>Neglect</p> <p>A- Staff in-serviced on expectations of neglect by Executive Director/designee. Resident R3 continues to reside in the community with no negative outcomes related to the deficient practice. E4 was removed from the schedule and subsequently resigned effective immedi- ately.</p> <p>B- All residents have the potential to be af- fected by the deficient practice.</p> <p>C- Education will be provided to all staff re- garding neglect upon hire and annually to en- sure compliance, by Executive Director/de- signee.</p> <p>D- The Healthcare Director/designee will re- view reportable incidents weekly to ensure that those incidents were reported timely and accurately, and that any staff issues will be dealt with immediately. Once this is achieved, the Healthcare Director/designee will conduct an audit 1 month later and if 100% compliance is achieved, the community will conclude the</p>	<p>4/24/26</p>

Provider's Signature *Shari A. Myello*

Title EXECUTIVE DIRECTOR Date 4/17/26



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<p>§ 1131.1 Definitions.</p>	<p>12/22/25 8:03 PM – The facility reported an allegation of staff to resident verbal abuse that occurred on 12/21/25 at 9:45 AM between E4 (LPN) and R5.</p> <p>3/31/26 – Review of the facilities daily schedules revealed that E4 (LPN) remained at the facility providing resident care on 12/21/25 after an alleged incident of verbal abuse against R5.</p> <p>3/31/26 1:26 PM – During an interview E4 (LPN) confirmed that she was not immediately removed from resident care following the allegation of staff to resident abuse involving herself and R5. E4 stated, "It happened on a weekend. The next day they called me into the office and sent me home."</p> <p>4/1/26 10:47 AM – During an interview E3 (former ED) confirmed that E4 (LPN) was not immediately removed from the facility following the alleged incident of staff to resident abuse that occurred on 12/21/25.</p> <p>4/1/26 1:30 PM – Findings were reviewed with E1 (NHA) and E2 (HD) during the exit conference.</p>	<p>deficient practice has been corrected. The reportable incident audits will be reviewed quarterly at QA during the evaluation period.</p>	

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<p><b>3225.0</b></p> <p><b>3225.16.0</b></p> <p><b>3225.16.2</b></p> <p><b>S/S – D</b></p>	<p>An unannounced Complaint Survey was conducted at this facility from March 31, 2026, through April 1, 2026. The deficiencies contained in this report are based on observations, interviews, review of resident’s clinical records, and review of other facility documents as indicated. The facility census on the first day of the survey was seventy - seven. The survey sample totaled seven residents.</p> <p>Abbreviations/definitions used in this report are as follows:</p> <p>ED - Executive Director;</p> <p>HD - Healthcare Director;</p> <p>LPN - Licensed Practical Nurse;</p> <p>MT - Medication Technician;</p> <p>POA – Power of Attorney;</p> <p>PCP – Primary Care Provider;</p> <p>RN - Registered Nurse;</p> <p>RA – Resident Assistant;</p> <p><b>Assisted Living Facilities</b></p> <p><b>Staffing</b></p> <p><b>A staff of persons sufficient in number and adequately trained, certified, or licensed to meet the requirements of the residents shall be employed and shall comply with applicable state laws and regulations.</b></p> <p><b>Per the State of Delaware Board of Nursing’s Scope of Practice document entitled “RN, LPN, and NA/UAP Duties 2024”, last revised 4/10/24, only a Registered Nurse (RN) can</b></p>		

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