

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

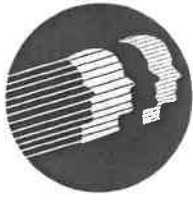
STATE SURVEY REPORT

NAME OF FACILITY: Harmony at Hockessin

DATE SURVEY COMPLETED: March 9, 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 Initial Survey was conducted at this facility from March 5, 2026, through March 9, 2026. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was thirty-seven (37). The survey sample totaled five (5) residents.</p> <p>Abbreviations/definitions used in this state report are as follows:</p> <p>Atrial Fibrillation (Afib) - A type of irregular heartbeat that may cause the heart to beat faster than usual. It is important to know that AFib increases the risk of stroke by about 5 times;</p> <p>BCC – Background Check Center/electronic system which combines data streams from various sources within and outside the State in order to assist an employer in determining the suitability of a person for employment in a nursing facility or similar facility;</p> <p>BOM – Business Office Manager;</p> <p>C – Concierge;</p> <p>CBC – Criminal background check/the process conducted by the State Bureau of Identification (SBI) of using an individual's fingerprints to identify the person and to conduct both a State and a Federal criminal background check;</p> <p>CT scan - A non-invasive imaging test that uses X-rays and computer processing to create detailed cross-sectional images of the body;</p>		

Provider's Signature [Signature] LNCFA Title Interim ED, ROPS Date 3/28/26



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	<p>DA – Dietary Aide;</p> <p>Dementia - A decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities;</p> <p>DHCQ – Division of Health Care Quality/division responsible for background checks for licensed facilities;</p> <p>DSD – Dining Services Director;</p> <p>DSM – Director of Sales and Marketing;</p> <p>DU - Dietary Utilities;</p> <p>ED - Executive Director;</p> <p>EMR – Electronic Medical Record;</p> <p>HCD - Health Care Director;</p> <p>Hematoma - A collection of blood outside a blood vessel, usually clotted, that forms when a blood vessel is damaged and blood leaks into surrounding tissues;</p> <p>HSD – Harmony Square Director;</p> <p>HSK – Housekeeping;</p> <p>LC – Lead Chef;</p> <p>LED – Life Enrichment Director;</p> <p>LS – Lead Server;</p> <p>MA – Maintenance Assistant;</p> <p>MD – Maintenance Director;</p> <p>MD2 – Marketing Director;</p> <p>MT – Med Tech;</p> <p>RA – Resident Assistant;</p> <p>Resident Assessment – evaluation of a resident’s physical, medical, and psychosocial</p>		

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<p>3225.0</p> <p>3225.9.0</p> <p>3225.9.5</p> <p>3225.9.5.2</p> <p>S/S – E</p>	<p>status as documented in a Uniform Assessment Instrument (UAI), by a Registered Nurse;</p> <p>RDRC – Regional Director of Resident Care;</p> <p>ROPS – Regional Operations;</p> <p>SA (Service Agreement) – allows both parties involved (the resident and the assisted living facility) to understand the types of care and services the assisted living provides. These include: lodging, board, house-keeping, personal care, and supervision services;</p> <p>UAI (Uniform Assessment Instrument) - A document setting forth standardized criteria developed by the Division to assess each resident's functional, cognitive, physical, medical, and psychosocial needs and status. The assisted living facility shall be required to use the UAI to evaluate each resident on both an initial and ongoing basis in accordance with these regulations.</p> <p>Assisted Living Facilities</p> <p>Infection Control</p> <p>Requirements for tuberculosis and immunizations:</p> <p>Minimum requirements for pre-employment require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as Quanti-Feron. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention</p>		

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	<p>of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review and review of other facility documentation, it was determined that for twelve (E5, E7, E8, E9, E11, E17, E18, E19, E21, E22 and E23) out of 15 sampled employees, the facility lacked evidence that the baseline two step tuberculin testing was done prior to hire or before the first resident admission on 11/24/25. Findings include:</p> <ol style="list-style-type: none"> 2/9/26 - E5 (DSD) was hired. The first step tuberculin test was administered on 2/20/26. The 2nd step was administered 3/6/26, both after E5's hire date. 7/10/25 - E7 (C) was hired. The first step tuberculin test was administered on 2/20/26. The 2nd step was administered 11/31/25, after the first resident admission on 11/24/25. 10/16/25 - E8 (MT) was hired. The first step tuberculin test was administered on 11/20/25. The 2nd step was administered 12/1/25, after the first resident admission on 11/24/25. 8/26/25 - E9 (LPN) was hired. The first step tuberculin test was administered on 11/20/25. The 2nd step was administered 	<p>3225.0 3225.9.0 3225.9.5 3225.9.5.2 S/S – E</p> <ol style="list-style-type: none"> Staff E5, E7, E8, E9, E11, E17, E18, E19, E 20, E21, E22 and E23 had TB standards completed and proof was placed in personnel file. No staff members will be permitted on the schedule until they are compliant. The Business Office Manager (BOM) or designee will conduct a full audit of all employees' pre-employment files to ensure pre-employment standards have been completed. The testing for applicants will be conducted by an independent 3rd party (Concentra Inc.) for the QuantiFeron test, by 4/10/26. This failed practice has the potential to affect all residents as identified by the current resident census. Executive Director and/or designee will in-service BOM of pre-employment standards regarding TB and immunization standards. The BOM or designee will ensure all newly hired staff have completed the 2 step TB skin test or lab draw, prior to employment. The BOM or designee will be responsible for ongoing audits, bi-monthly. Executive Director/designee will audit files of newly hired staff monthly to ensure compliance. An auditing tool will be used and it will be incorporated into the Quality Assurance and Performance Improvement process. 	<p>Completion Date: 04/10/26 and ongoing</p>

Provider's Signature  LNKA

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	<p>12/11/25, after the first resident admission on 11/24/25.</p> <p>5. 8/22/25 - E11 (LPN) was hired. The first step tuberculin test was administered on 11/20/25. The 2nd step was administered 12/1/25, after the first resident admission on 11/24/25.</p> <p>6. 9/18/25 - E17 (HSK) was hired. The first step tuberculin test was administered on 11/20/25. The 2nd step was administered 12/3/25, after the first resident admission on 11/24/25.</p> <p>7. 9/19/25 - E18 (MT) was hired. The first step tuberculin test was administered on 11/20/25. The 2nd step was administered 12/11/25, after the first resident admission on 11/24/25.</p> <p>8. 11/18/25 - E19 (RA) was hired. The first step tuberculin test was administered on 11/20/25. The 2nd step was administered 12/3/25, after the first resident admission on 11/24/25.</p> <p>9. 8/18/25 - E20 (LS) was hired. The first step tuberculin test was administered on 11/20/25. The 2nd step was administered 12/1/25, after the first resident admission on 11/24/25.</p> <p>10. 11/18/25 - E21 (RA) was hired. The first step tuberculin test was administered on 11/20/25. The 2nd step was administered 12/3/25, after the first resident admission on 11/24/25.</p> <p>11. 11/7/25 - E22 (DA) was hired. The first step tuberculin test was administered on 11/20/25. The 2nd step was administered</p>		

Provider's Signature Title Tuberculin ED, ROPS Date 3/29/26



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<p>3225.9.0 3225.9.9 3225.9.9.1 3225.9.9.1.1 S/S- F</p>	<p>12/1/25, after the first resident admission on 11/24/25.</p> <p>12. 1/13/25 - E23 (MD2) was hired. The first step tuberculin test was administered on 11/20/25. The 2nd step was administered 11/30/25, after the first resident admission on 11/24/25.</p> <p>3/6/26 12:12 PM – Per interview with E4 (BOM), E4 stated the company policy is to do the QuantiFeron testing for all employees but the lab being used pulled out of the testing. E4 stated the facility experienced supply issues in obtaining the tuberculin serum. E4 stated many employees transferred from other facilities.</p> <p>3/9/26 2:00 PM, per interview with E1 (ED), E1 confirmed they were unable to get the serum and once received, there was mass administration on 11/20/25.</p> <p>3/9/26 - Findings were reviewed with E1, E2 (HCD), E3 (HSD), E12 (ROPS) and E13 (RDRC) at the exit conference, beginning at approximately 2:10 PM.</p> <p>Infection Control</p> <p>Infection Prevention and Control Program</p> <p>The assisted living facility shall establish an infection prevention and control program with shall be based upon Centers for Disease Control and Prevention and other nationally recognized infection prevention and control guidelines.</p> <p>The infection prevention and control program must cover all services and all areas of the assisted living facilities, including</p>	<p>3225.9.0 3225.9.9 3225.9.9.1 3225.9.9.1.1 S/S- F</p> <p>1. The Maintenance Director(MD) installed the soap and paper towel dispensers into all three of the laundry rooms on 3/12/2026.</p> <p>2. This failed practice has the potential to affect all residents as identified by the current resident census.</p> <p>3. Executive Director (ED) in-serviced Maintenance Director(MD) regarding Infection Control measures. MD/designee will monitor these dispensers weekly to ensure that they remain supplied with soap. ED will audit laundry areas in the community, monthly, to ensure compliance. The MD or designee will add the monitoring and resupply audit to the facility's quarterly Quality Assurance and Performance Improvement process.</p>	<p>Date of completion: 04/10/2026</p>

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<p>3225.11.0 3225.11.3 S/S – D</p>	<p>provision of the appropriate personal protective equipment for all residents, staff and visitors.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on observations, it was determined that the facility failed to comply with infection control procedures for laundry services. Findings include:</p> <p>3/6/26 – During the survey of the facility at approximately 3:00 PM, an observation of the laundry facilities lacked handwashing soap or dispensers in 3/3 laundry rooms.</p> <p>3/6/26 4:00 PM – During an interview with E1, the findings were confirmed.</p> <p>Resident Assessment</p> <p>Within 30 days prior to admission, a prospective resident shall have a medical evaluation completed by a physician.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review, interview and review of other facility documentation, it was determined that for one (R5) out of five sampled residents, the facility failed to provide evidence that the physician's evaluation was completed within 30-days prior to admission. Findings include:</p> <p>11/25/25 – R5 was admitted to the facility. The physician's evaluation indicated the pre-admission evaluation visit was completed on 9/30/25, not within the 30 days prior to admission.</p>	<p>3225.11.0 3225.11.3 S/S – D</p> <p>1.The Healthcare Director (HCD) or designee will conduct a full audit of all residents to ensure that the physician's evaluation was completed within 30 day prior to admission. Any concerns will be corrected immediately. Resident R5 continues to reside in the community.</p> <p>2. This failed practice has the potential to affect all residents as identified by the current resident census.</p> <p>3. The HCD/designee will screen all new admissions to ensure that a medical evaluation by the Primary Care Provider (PCP) is completed prior to admission. A move-in checklist has been implemented for this purpose. LPNs, the HSD, and the admissions team were in serviced by the ED on utilizing the move-in checklist before a resident's admission. Residents will not be admitted to the facility until all necessary documentation has been completed and reviewed.</p>	

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<p>3225.12.0 3225.12.1 3225.12.1.3 S/S – F</p>	<p>3/9/26 2:00 PM – Per interview with E2 (HCD), E2 stated R5's admission was delayed, and the son took her back to the physician to have an evaluation completed. E2 stated the physician signed it 11/24/25, which is when the physician's office faxed it to the facility. E2 stated she believed the physician did not change the initial 9/30/25 visit date as to when the revisit was completed. The surveyor found no evidence to support this.</p> <p>3/9/26 - Findings were reviewed with E1 (ED), E2, E3 (HSD), E12 (ROPS) and E13 (RDRC) at the exit conference, beginning at approximately 2:10 PM.</p> <p>Services</p> <p>The assisted living facility shall ensure that:</p> <p>Food service complies with the Delaware Food Code</p> <p>This requirement was not met as evidenced by:</p> <p>Based on observations, interviews, and review of other facility documentation it was determined that the facility failed to comply with the Delaware Food Code. Findings include:</p> <p>Delaware Food Code</p> <p>2-101.11 Assignment. (A) Except as specified in ¶ (B) of this section, the PERMIT HOLDER shall be the PERSON IN CHARGE or shall designate a PERSON IN CHARGE and shall ensure that a PERSON IN CHARGE is present at the FOOD ESTABLISHMENT during all hours of operation.</p>	<p>(continued)</p> <p>3225.11.0 3225.11.3 S/S – D</p> <p>3 cont... The HCD or designee will conduct a monthly audit on all new admissions to ensure a medical evaluation was completed within 30 days prior to admission for 3 months or until 100% compliance is achieved. The results will be reviewed and monitored through the facility's Quality Assurance Performance Improvement process.</p>	<p>Completion Date: 04/10/26 and ongoing</p>

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	<p>2-102.12 Certified Food Protection Manager (A) At least one employee, the PERSON IN CHARGE at the time of inspection, shall be a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM.</p> <p>3/6/26 11:00 AM – During the survey of the facility and interview with E5 (DSD) revealed there was no certified food protection manager (CFPM) on duty. A request of CFPM certifications revealed one employee had a certificate that expired on October 13, 2025.</p> <p>2-402.11 Effectiveness. (A) Except as provided in ¶ (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLESERVICE and SINGLE-USE ARTICLES.</p> <p>3/6/26 11:00 AM – During the survey of the facility, E26 (LC) was observed not wearing a beard net during lunch preparation.</p> <p>3-501 Temperature and Time Control 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or</p>	<p>3225.12.0 3225.12.1 3225.12.1.3 S/S – F</p> <p>1. 2-101.11- Dining Service Director (DSD) is registered and paid for 4/21/26, Servsafe manager course. The remaining cooks will also be certified. 2-402.11 Kitchen staff were in-serviced by DSD on 3/1/26 regarding policies and expectations on beard nets, with beard nets being resupplied. 3-501.16 In-services were conducted on policies and procedures for food safety and mandatory food temp logs on 3/1/26 by the new DSD. 4-204.112 Thermometers for all reach-ins were ordered and will be placed in areas upon arrival. 4-302.13 Dishwashing temperatures were adjusted to be corrected with Ecolab servicing the machine on 3/6/26. 6-201.11 The dining team was in-service on cleaning policies and procedures for walls, floors, ceilings, with assignments for AM and PM shifts, by DSD. 6-403.11 The dining team in-service on policies regarding the storage of personal beverages in designated areas, by DSD.</p> <p>2. This failed practice has the potential to affect all residents as identified by the current resident census.</p>	

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	<p>above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; P or (2) At 5oC (41oF) or less.</p> <p>3/6/26 1:30 PM – During the survey of the facility, a review of food temperature documentation found missing food temperature logs. A review of logs between November 1, 2025, through February 28, 2026, revealed 270/360 missing temperature logs.</p> <p>4-204.112 Temperature Measuring Devices. (A) In a mechanically refrigerated or hot FOOD storage unit, the sensor of a TEMPERATURE MEASURING DEVICE shall be located to measure the air temperature or a simulated product temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot FOOD storage unit.</p> <p>3/6/26 12:00 PM – During the survey of the facility, an observation of the reach in refrigerators in the kitchen and the memory care kitchenette revealed that there were no thermometers positioned in the warmest part of the refrigerators.</p> <p>4-302 Utensils, Temperature Measuring Devices, and Testing Devices. 4-302.13 Temperature Measuring Devices, Manual and Mechanical Warewashing. (B) In hot water mechanical WAREWASHING operations, an irreversible registering temperature indicator shall be provided and</p>	<p>(Continued...) 3225.12.0 3225.12.1 3225.12.1.3 S/S – F</p> <p>3. The DSD or designee will in-service all new staff, upon hire, regarding kitchen standards. DSD will audit the areas noted by the surveyor, weekly, to ensure compliance and maintain documentation of the audits. Documented in-services with the team and review of policies and procedures will be ongoing. The DSD or designee will inspect all cleaning schedules listed to ensure sanitation standards are met and remain compliant, weekly. The Executive Director or designee will continue to perform inspections to ensure compliance, monthly. The results will be reviewed and monitored through the facility's Quality Assurance Performance Improvement process.</p>	<p>Completion Date: 04/21/26 and ongoing</p>

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	<p>readily accessible for measuring the UTENSIL surface temperature.</p> <p>3/6/26 3:15 PM– During the survey of the facility, a review of the dishwasher operating temperature revealed a 140-degree Fahrenheit wash temperature and 190 degrees Fahrenheit rinse temperature. According to the data plate, the wash temperature for the high temperature sanitation revealed the required wash temperature was 150 degrees Fahrenheit. Eco Lab had serviced the machine this same day. An irreversible registering temperature indicator was not available to measure the utensil surface temperature.</p> <p>6-201.11 Floors, Walls, and Ceilings.</p> <p>Except as specified under § 6-201.14 and except for antislip floor coverings or applications that may be used for safety reasons, floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are SMOOTH and EASILY CLEANABLE.</p> <p>3/6/26 11:00 AM – During the survey of the facility, an observation of the kitchen revealed debris on the floor surrounding the cooking equipment.</p> <p>6-403.11 Designated Areas. (A)Areas designated for EMPLOYEES to eat, drink, and use tobacco shall be located so that FOOD, EQUIPMENT, LINENS, and SINGLESERVICE and SINGLE-USE ARTICLES are protected from contamination.</p>		

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<p>3225.13.0 3225.13.3 S/S – D</p>	<p>3/6/26 11:00 AM– During the survey of the facility, personal items were observed located in the food service area. This included a wawa coffee cup near the coffee and juice area and an open can of sprite in the walk in.</p> <p>3/6/26 11:00 AM – During an interview with E25 (DU), E25 confirmed the open can of sprite was in the walk in food service area.</p> <p>3/6/26 4:00 PM – During an interview with E1 (ED) and E5 (DSD), the Delaware food Code findings were confirmed.</p> <p>Service Agreements</p> <p>The resident’s personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review, interview and review of other facility documentation, it was determined that for one (R2) out of five sampled residents, the facility lacked evidence that the Service Agreements (SA) contained the residents’ attending physician’s information. Findings include:</p> <p>1/20/26 – R2 was admitted to the facility. The facility lacked evidence that the SA completed on 1/6/26 contained any of the physician’s information.</p> <p>3/9/26 2:00 PM – Per a combined interview with E2 (HCD) and E13 (RDRC), E2 confirmed that the physician information was not completed on this service agreement. E13 stated the current EMR program does not have a</p>	<p>3225.13.0 3225.13.3 S/S – D</p> <ol style="list-style-type: none"> 1.The Healthcare Director (HCD)/designee corrected resident R2 physician information. The HCD/designee have updated all service plans to incorporate the necessary physician demographic information. 2. This failed practice has the potential to affect all residents as identified by the current resident census. 3. Executive Director in-serviced all nurses regarding requirement of physician information. The HCD or designee conducted an audit of resident files to ensure all required information is updated and added to the SA. The HCD or designee will conduct bi-monthly audits of resident charts to ensure that physician demographics are added to the SA. These audits will continue until we achieve 100% compliance. This auditing process will also be monitored through the facility’s Quality Assurance and Performance Improvement meetings. 	<p>Completion Date: 04/10/26 and ongoing</p>

Provider’s Signature *[Signature]* LNHA Title I-Twin ED, ROPS Date 3/20/26



DELAWARE HEALTH AND SOCIAL SERVICES

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

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STATE SURVEY REPORT

NAME OF FACILITY: Harmony at Hockessin

DATE SURVEY COMPLETED: March 9, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
<p>3225.19.0</p> <p>3225.19.6</p> <p>3225.19.7</p> <p>3225.19.7.7</p> <p>3225.19.7.7.2</p> <p>S/S – D</p>	<p>prompt to enter the information, and it must be entered manually.</p> <p>3/9/26 - Findings were reviewed with E1 (ED), E2, E3 (HSD), E12 (ROPS) and E13 at the exit conference, beginning at approximately 2:10 PM.</p> <p>Records and Reports</p> <p>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.</p> <p>Reportable incidents include:</p> <p>Significant injuries.</p> <p>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.</p> <p>Based on record review, interview and review of other facility documentation, it was determined that for one (R5) out of five sampled residents, the facility lacked evidence that three falls with injury were reported within the regulation guidelines. Findings include:</p> <p>11/25/26 – R5 was admitted to the facility with diagnoses including dementia and atrial fibrillation. R5's medications included Eliquis (blood thinner).</p> <p>1/1/26 4:02 AM – Per EMR entry by E16 (LPN), R5 activated the bathroom call bell and was found on the floor. R5 stated she hit her head on the bathroom wall and had</p>	<p>3225.19.0 3225.19.6 3225.19.7 3225.19.7.7 3225.19.7.7.2 S/S – D</p> <p>1.The Executive Director (ED)or designee in-serviced all staff on reportable incidents, including use of WellSky for reporting and the importance of timely notifications.</p> <p>2. This failed practice has the potential to affect all residents as identified by the current resident census.</p> <p>3.The ED/designee will train new hired staff regarding reporting standards, upon hire and annually, to ensure compliance. The ED or designee will conduct incident report audits monthly, ensuring all reportable incidents are properly documented and reported appropriately and timely. This auditing process will also be monitored through the facility's Quality Assurance Committee Meetings.</p>	<p>Completion Date: 04/10/26 and ongoing</p>

Provider's Signature [Signature] LNHA Title Interim ED, ROPS Date 3/29/26



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STATE SURVEY REPORT

NAME OF FACILITY: Harmony at Hockessin

DATE SURVEY COMPLETED: March 9, 2026

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	<p>some noted bruising on her back. A tele-health evaluation was completed by E2 (HCD) and PRN pain medication was administered.</p> <p>1/1/26 6:38 AM- Per EMR entry by E16, R5 called for assistance due to excruciating pain to left side. 911 was notified and R5 was transported to the ER for evaluation.</p> <p>1/2/26 12:11 PM – Per EMR entry by E11 (LPN), R5 was being admitted for an abdominal hematoma and a UTI (urinary track infection.)</p> <p>1/4/26 – Per hospital discharge summary, R5 proved to have a left abdominal wall hematoma with focus of active extravasation (leakage of blood). Per the abdominal CT scan report, R5 had an 8.1 x 2.9 centimeters hematoma with indication of active bleeding. R5 was admitted monitoring the abdominal wall hematoma for serial trending of her hemoglobin.</p> <p>The facility failed to report this fall with injury to the State Agency Reporting System.</p> <p>1/5/26 12:45 AM – Per EMR entry by E14 (LPN), on 1/4/26 at 9:45 PM, R5 returned from the hospital to the facility.</p> <p>1/5/26 1:24 AM – Per EMR entry by E16 (LPN) noted that at 1:15 AM, ambulance personnel arrived at the facility due to R5 calling 911 herself. On entry to room, R5 was found on the floor with her walker flipped over and noted to have a hematoma to the back of her head. She was transported to the ER for evaluation.</p>		

Provider's Signature  LNUHA Title Intervenor ED, ROPS Date 3/20/26



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NAME OF FACILITY: Harmony at Hockessin

DATE SURVEY COMPLETED: March 9, 2026

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	<p>1/5/26 – Per hospital CT scan, R5 was reported a have fracture along the posterior and lateral aspects of the 11th rib.</p> <p>1/6/26 12:58 PM – Per EMR entry by E9 (LPN), R5 was being admitted for pleural ef-fusion and a fractured rib.</p> <p>1/10/26 1:10 AM – Per EMR entry by E14 (LPN), R5 returned to the facility from the hospital on 1/9/26 at 8:20 PM. E14 noted R5 was treated for a pleural effusion a frac-tured 11th rib.</p> <p>The facility failed to report this fall with injury to the State Agency Reporting System.</p> <p>1/15/26 9:15 PM – Per EMR entry by E14 (LPN), R5 had an unwitnessed fall and was found on the floor complaining of severe shoulder pain. R5 was transported to the ER for evaluation.</p> <p>1/16/26 6:00 AM – Per EMR entry by E15 (LPN), the hospital was contacted for status update on R5 and found that R5 was being admitted for a fractured humerus.</p> <p>1/16/26 7:58 PM – E2 reported the fall with injury to the State Agency Reporting System, over 12 hours later, not within the eight-hour regulation requirement.</p> <p>3/9/26 2:00 PM – Per interview with E2 (HCD) confirmed the 1/1/26 and 1/5/26 falls with injury were not reported by the facility and that the 1/16/26 fall with injury was not reported within the eight-hour regulation.</p> <p>3/9/26 - Findings were reviewed with E1 (ED), E2, E3 (HSD), E12 (ROPS) and E13</p>		

Provider's Signature [Signature] Title Interim ED, ROPS Date 3/20/26



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STATE SURVEY REPORT

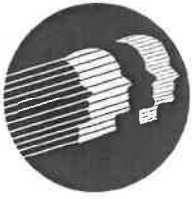
NAME OF FACILITY: Harmony at Hockessin

DATE SURVEY COMPLETED: March 9, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
<p>Title 16 DE Code - Health and Safety</p> <p>Regulatory Provisions Concerning Public Health Chapter 11 Long Term Care Facilities and Services Subchapter IV Criminal Back-ground Checks; Mandatory Drug Screening; Long-Term Care Facilities; Nursing Home Compliance with Title XIX of the Social Security Act.</p> <p>§ 1141 Criminal Background Checks</p> <p>S/S – E</p>	<p>(RDRC) at the exit conference, beginning at approximately 2:10 PM.</p> <p>(a) Purpose. — The purpose of the criminal background check and drug screening requirements of this section and § 1142 of this title is the protection of the safety and well-being of residents of long-term care facilities licensed pursuant to this chapter. These sections shall be construed broadly to accomplish this purpose.</p> <p>(b) Definitions. —</p> <p>(1) "Applicant" means any of the following:</p> <p>(a) A person seeking employment in a facility.</p> <p>(c) An employer may not employ an applicant for work in a facility before obtaining a criminal history. The criminal history of any person not employed directly by the facility must be provided to the facility upon the person's commencement of work.</p> <p>(d) The requirements of subsection (c) of this section may be suspended for 60 days if the employer wishes to employ the applicant on a conditional basis.</p> <p>(d)(1) Before an employer may offer conditional employment, the employer must receive verification that the applicant has been fingerprinted by the SBI for purposes of the criminal history.</p> <p>(h) An applicant may not be employed in a facility, other than conditionally under sub-</p>	<p>Title 16 DE Code - Health and Safety Regulatory Provisions Concerning Public Health. Chapter 11 Long Term Care Facilities and Services. Subchapter IV Criminal Background Checks; Mandatory Drug Screening; Long-Term Care Facilities; Nursing Home Compliance with Title XIX of the Social Security Act. § 1141 Criminal Background Checks</p> <p>S/S – E</p> <p>1. Background checks for E3, E18, E19, E21, E23, E24 were completed and placed in file. No staff members will be permitted on the schedule unless they are compliant.</p> <p>2. This failed practice has the potential to affect all residents as identified by the current resident census.</p> <p>3. The Business office Manager (BOM)/designee will review all current employee records and new hire employee applications to confirm their background status to ensure compliance. The BOM or designee will conduct audits of employee files, bi-monthly, ensuring all background checks were completed timely per regulatory guidelines and clear of any criminal history that would bar them from employment. No person will be permitted on the schedule unless they are compliant. Executive Director/designee will audit files monthly to ensure compliance. This process will be incorporated into the facility's Quality Assurance and Performance Improvement process.</p>	<p>Completion Date: 04/10/26 and ongoing</p>

Provider's Signature: [Signature] LNHA

Title Intarim ED, ROS Date 3/28/26



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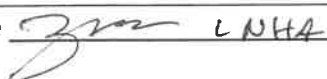
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STATE SURVEY REPORT

NAME OF FACILITY: Harmony at Hockessin

DATE SURVEY COMPLETED: March 9, 2026

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	<p>section (d) of this section, until the applicant's employer has secured the applicant's criminal history.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review, interview and review of the DHCQ BCC information, it was determined that for six (E3, E18, E19, E21, E23 and E24) out of 15 sampled employees, the facility lacked evidence that the criminal background checks were obtained prior to hire. The remaining nine employees were in the BCC profile but not affiliated with this facility. Findings include:</p> <p>3/9/26 1:00 PM – Per interview with E1 (ED), E1 stated the facility had no access to the BCC until a facility license was issued. This license was obtained on 11/19/25. E1 stated he requested access on 11/20/25 but only received the access as of 2/25/26. E1 stated no staff had been fingerprinted since hired at this facility since he did not have access to the BCC.</p> <p>Review of the following staff personnel records and DHCQ BCC with E1 revealed that the following six staff lacked evidence of any profile in the BCC system prior to working in the facility:</p> <ul style="list-style-type: none"> -E3 (HSD) hired 7/28/25 -E18 (MT) hired 9/19/25 -E19 (RA) hired 11/18/25 -E21 (RA) hired 11/18/25 -E23 (MD2) hired 1/13/25 		

Provider's Signature  Title Interim ED, ROPS Date 3/28/26



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<p>1142. Mandatory drug screening. S/S – D</p>	<p>-E24 (MA) hired 3/2/26</p> <p>3/9/26 2:00 PM, per interview with E3 (HSD), E3 stated she was fingerprinted prior to employment however it was under another facility's identification.</p> <p>3/9/26 - Findings were reviewed with E1, E2 (HCD), E3, E12 (ROPS) and E13 (RDRC) at the exit conference, beginning at approximately 2:10 PM.</p> <p>(a) An employer may not employ an applicant without first obtaining the results of that applicant's mandatory drug screening.</p> <p>(c) The Department shall promulgate regulations, regarding the pre-employment testing of all applicants, for use of all of the following illegal drugs:</p> <p>(1) Marijuana/cannabis.</p> <p>(2) Cocaine.</p> <p>(3) Opiates.</p> <p>(4) Phencyclidine ("PCP").</p> <p>(5) Amphetamines.</p> <p>(6) Any other illegal drug specified by the Department under regulations promulgated under this section.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review, interview and review of other facility documentation, it was determined that for one (E7) out of four sampled employees, the facility lacked evi-</p>	<p>1142. Mandatory drug screening. S/S – D</p> <p>1.E7 will be tested for all required drugs and proof will be placed in file by April 10th, 2026. The Business Office Manager or designee will conduct a full audit of all employees' pre-employment paperwork and current drug screening test result status, ensuring all comply with the minimum requirements</p> <p>2. This failed practice has the potential to affect all residents as identified by the current resident census.</p> <p>3.The Business Office Manager or designee will conduct a full audit of all employees' pre-employment paperwork and current drug screening test result status, bi-monthly, ensuring all comply with the minimum requirements. Any errors found will be corrected immediately. The Executive Director will audit personnel files monthly to ensure compliance. An auditing tool will be used, and it will be incorporated into the Quality Assurance and Performance Improvement process.</p>	<p>Completion Date: 04/10/26 and ongoing</p>

Provider's Signature 

Title Interim EO, ROPS Date 3/28/26



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<p>Title 24 -Professions and Occupations</p> <p>Chapter 60- Provisions Applicable to Telehealth and Telemedicine</p> <p>6001 Definitions,</p> <p>S/S - D</p>	<p>dence that the pre-hire drug screening contained testing for marijuana/cannabis. Findings include:</p> <p>7/10/25 - E7 (C) was hired at the facility. The pre-hire drug testing done on 7/10/25 did not contain testing for marijuana/cannabis.</p> <p>3/6/26 12:40 PM – Per interview with E1 (ED), E1 confirmed the pre-hire testing for marijuana/cannabis was not completed for E7. E1 stated the initial form the facility was utilizing did not contain the cannabis testing. When discovered, E1 stated all employees were retested, but confirmed E7 retesting must have been missed.</p> <p>3/9/26 - Findings were reviewed with E1, E2 (HCD), E3 (HSD), E12 (ROPS) and E13 (RDRC) at the exit conference, beginning at approximately 2:10 PM.</p> <p>(5) "Telehealth" means the use of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, health administration or other services as described in regulation.</p> <p>6003 Scope of practice; provider-patient relationship required.</p> <p>(a) Except for the instances listed in the chapter, health-care providers may not deliver health-care services by telehealth and telemedicine in the absence of a health-care provider-patient relations. A health-care provider-patient relationship my be</p>		

Provider's Signature   Title Interim ED, ROPS Date 3/28/26



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	<p>established either in-person or through telehealth and telemedicine but must include all of the following:</p> <p>(3) Receipt of appropriate consent from a patient after disclosure regarding the delivery model and treatment method or limitations, including informed consent regarding the use of telemedicine technologies as required by paragraph (a)(5) of this section.</p> <p>(5) Discussion with the patient of any diagnosis and supporting evidence as well as risks and benefits of various treatment options.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review, interview and review of other facility documentation, it was determined that for one (R5) out of five residents sampled, the facility failed to have evidence that a consent was obtained prior to telehealth use.</p> <p>11/25/26 – R5 was admitted to the facility.</p> <p>12/27/26 2:50 AM – Per EMR entry by E16 (LPN), E16 noted R5 was found on the floor at 1:20 AM with complaint of hitting her head and back on the wall. E16 noted that E2 (HCD) was notified and performed a telehealth visit to evaluate R5 post fall.</p> <p>1/1/26 4:02 AM – Per EMR entry by E16, E16 noted R5 was found on the floor at 3:00 AM stating she hit her head during the fall. E16</p>	<p>Title 24 -Professions and Occupations Chapter 60-Provisions Applicable to Telehealth and Telemedicine 6001 Definitions, S/S - D</p> <p>1. Resident R5 will sign a consent form related to the use of Telehealth within the facility. The Business Office Manager(BOM)/designee conducted an audit of all resident files to ensure consent of “telehealth” can be utilized.</p> <p>2. This failed practice has the potential to affect all residents as identified by the current resident census.</p> <p>3. The Executive Director (ED)/ designee will conduct an audit of all admissions records to ensure that the “telehealth” consent form has been signed by the resident or POA. The ED/designee will ensure that the preadmission paperwork includes the “Telehealth” consent form. The BOM/designee will audit resident files, bi-monthly, to ensure the residents’ “telehealth” consent forms are signed. This process will be incorporated into the facility’s Quality Assurance and Performance Improvement process.</p>	<p>Completion Date: 04/15/26 and ongoing</p>

Provider's Signature  L NHA Title Tutor in ED, POB Date 3/20/26



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	<p>noted that E2 (HCD) was notified and performed a telehealth visit to evaluate R5 post fall.</p> <p>3/9/26 – The surveyor found no evidence the facility obtained telehealth consent from R5 or the PoA.</p> <p>3/9/26 2:00 PM – Per combined interview with E2 and E13 (RDRC), E2 stated the facility had not obtained telehealth consents on any residents. E13 confirmed the finding and stated a telehealth consent addendum would be created for residents to sign.</p> <p>3/9/26 - Findings were reviewed with E1 (ED), E2, E3 (HSD), E12 (ROPS) and E13 at the exit conference, beginning at approximately 2:10 PM.</p>		

Provider's Signature Title Interim ED, ROPS Date 3/20/26