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 Kent

DATE SURVEY COMPLETED: May 27, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Annual and Complaint survey was conducted at this facility from May 19, 2026, through May 27, 2026. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents as indicated. The facility census on the first day of survey was eighty - two (82). The survey sample totaled fifteen (15) residents. Abbreviations/definitions used in this report are as follows: C. difficile (Clostridioides difficile) - a highly contagious bacterium that infects the large intestine (colon); DA – Dietary Aide; Diltiazem – cardiac medication; Ezetimibe – high blood pressure ED – Executive Director; LC – Lead Cook; LH – Lead Housekeeper; LPN – Licensed Practical Nurse; RA – Resident Assistant; QuantiFeron – blood test for tuberculosis test; RDO- Regional Director of Operations; RDRC- Regional Director of Resident Care; TST – two-step tuberculin skin test for tuberculosis test; RD – Regional Director Resident Care;		

Provider's Signature [signature] Title Executive Director Date 6/26/26

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	Service Plan – 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, housekeeping, personal care and supervision services; Simvastatin – lower cholesterol UAI – 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 the ongoing basis. Vitamin D- a nutrient that your body needs to absorb calcium, build strong bones, and keep your immune system running smoothly.		
3225.8.8 3225.8.8.2 S/S – D	**Concurrently with all Uniform Assessment Instrument (UAI) -based assessments, the assisted living facility shall arrange for an on-site medication review by a registered nurse, for residents who need assistance with self-administration or staff administration of medication, to ensure that:** **Each resident receives the medications that have been specifically prescribed in the manner that has been ordered.** **This requirement was not met as evidenced by:** Based on interview and record review, it was determined that for one (R14) out of five (5) residents reviewed for medica-	**3225.8.8.2** 1. Corrective action(s) accomplished for affected resident(s): Resident R14's medication regimen was immediately reviewed upon identification of the deficient practice. Physician orders were obtained, verified, and transmitted to the pharmacy. All prescribed medications (memantine, diltiazem, ezetimibe/simvastatin, and Vitamin D3) were initiated. The nurse practitioner was notified and assessed the resident for any adverse outcomes related to missed medications. Documentation was updated in the resident's clinical record. 2. How other residents having the potential to be affected were identified and corrected: This failed practice has the potential to affect all residents as identified by the resident census. 3. Systemic changes implemented to prevent recurrence:	Completion Date: 7/10/2026 and ongoing

Provider's Signature [signature] Title Executive Director Date 6/26/26

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	tion administration, the facility failed to ensure R14 received medications as prescribed. Findings include: 12/8/25 – An admission UAI documented R14 was severely cognitively impaired. 1/2/26 - R14 was admitted to the facility with a diagnosis of dementia. 1/2/26 – 3/18/26 – The facility lacked evidence of medication orders for R14. 3/18/26 9:05 AM – After the incident, a physician order for R14 documented memantine 5mg PO daily, diltiazem 120 mg PO daily, ezetimibe 10 mg – simvastatin 20mg PO daily, and vitamin D3 500 IU 125 mcg PO daily. 3/18/26 12:00 PM - An incident report documented that R14 did not receive her memantine 5mg, diltiazem 120 mg, ezetimibe 10 mg – simvastatin 20mg, and vitamin D3 500 IU 125 mcg from 1/2/26 to 3/18/26. 3/18/26 4:44 PM - A progress note documented that the nurse practitioner was notified and that medications were ordered and faxed to the pharmacy. 5/21/26 1:32 PM - During an interview, E6 (LPN) explained that when a resident is admitted into the facility, she does not handle medication scripts. She stated that the Director of Nursing is responsible for verifying the orders with the provider and faxing the medication script to the pharmacy. On 3/18/26, E6 was reviewing R14's medications and noticed the resident had no medications ordered. E6 then notified E1(ED), 7	A Report of Physical Examination was implemented requiring verification that physician orders are received, reviewed, faxed/transmitted to the pharmacy, entered into the MAR, and reconciled within 24 hours of admission. The Health Care Director, and nursing staff received re-education, by Executive Director, regarding medication admission procedures and order verification responsibilities. 4. Monitoring/Quality Assurance: The Health Care Director or designee will conduct weekly audits of all new admissions and medication reconciliations for 4 weeks, then monthly for 3 months. Audit findings will be reported to the facility Quality Assurance committee. Corrective actions will be implemented immediately for any identified discrepancies.	

Provider's Signature [signature] Title Executive Director Date 6/21/26

NAME OF FACILITY: Harmony at Kent

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3225.9.0 3225.9.3 S/S – D	**Infection Control** **A resident, when suspected or diagnosed as having a communicable disease, shall be placed on the appropriate isolation or precaution as recommended for that disease by the Centers for Disease Control. Those with a communicable disease that has been determined by the Director of the Division of Public Health to be a health hazard to visitors, staff, and other residents shall be placed on isolation care until they can be moved to an appropriate room or transferred.** **This requirement was not met as evidenced by:** Based on observation, interview, and record review, it was determined that for one (R7) out of five residents reviewed for infection control, the facility failed to follow an infection control program using contact precautions. Findings include: 7/16/25 - An admission UAI documented R7 was alert and oriented. 8/18/25 – R7 was admitted to the facility. 5/17/26 2:34 PM – A progress note documented that when R7 was in the ER, he was confirmed to have Clostridioides difficle (C. difficile) and began antibiotic treatment. 5/19/26 8:15 AM - An observation made inside and outside R7's room revealed that there was no PPE available. In addition, there was no sign on R7's door designating what type of precautions to use for the care of the resident.	**3225.9.0** 1. Corrective action(s) accomplished for affected resident(s): Upon identification of the deficiency, appropriate contact precaution signage was placed at Resident R7's room entrance. Personal protective equipment (PPE), including gowns and gloves, was immediately made available outside the resident's room. Staff were re-educated on infection control practices and CDC recommendations regarding C. difficile precautions. 2. How other residents having the potential to be affected were identified and corrected: This failed practice has the potential to affect all residents as identified by the resident census. 3. Systemic changes implemented to prevent recurrence: The facility requires immediate implementation of the appropriate or precautions recommended by the CDC. Executive Director re-educated nursing staff and caregiving staff regarding infection control requirements and facility policies. 4. Monitoring/Quality Assurance: The Health Care Director or designee will audit all residents with communicable diseases for implementation of infection control practices. Audits will include verification of PPE availability, signage, and staff compliance with precautions. Results will be reviewed by the QA Committee, and corrective actions will be implemented as needed.	Completed By: 7/10/2026 and ongoing.

Provider's Signature [signature] Title Executive Director Date 6/24/26

NAME OF FACILITY: Harmony at Kent

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	5/20/26 9:00 AM – An observation made inside and outside R7's room revealed that there was no PPE available. In addition, there was no sign on R7's door designating what type of precautions to use for the care of the resident. 5/21/26 8:15 AM – An observation of facility staff placing PPE bins outside of R7's room. 5/21/26 8:30 AM – During an interview, E4 (MT) stated that R7's room is required to have a gown and gloves available because the resident has a C. difficile infection. 5/21/26 8:35 AM - During an interview, E5 (LPN) stated that once a resident is suspected to have C. difficile, isolation bins are placed either in the resident's room or outside the resident's door. Also, they place a transmission-based precaution sign on the door. E5 confirmed that R7's room did not have the required gowns and gloves readily available. 5/21/26 9:00 AM - During an interview with E1 (ED), the findings were confirmed, and E1 stated that gowns and gloves are required to be available in the residents' room. 5/27/26 10:30 AM – Findings were reviewed at the exit conference with E1 (ED) and E2 (RCRD). **Requirement for Tuberculosis and immunization:**		

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3225.9.5 3225.9.5.2 3225.9.5.2.4 S/S – E	**Minimum requirements for pre-employment require all employees to have a baseline two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention 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.** **A report of all test results shall be kept on file at the facility of employment.** **These requirements were not met as evidenced by:** Based on interview, record review and review of other facility documentation it was determined that for seven (E9, E10, E11, E12, E13, E14, and E15) out eight (8) employees sampled for tuberculosis testing the facility lacked evidence of a two-step tuberculin having been completed. Findings include: 12/10/25 – E15 (DA) was hired. There was lack of evidence provided by the facility that a TST, IGRA, or QuantiFeron test was performed. 1/21/26 – E9 (RA) was hired. A first step TST (Tuberculin Skin Test) was performed. The	**3225.9.5** 1. Corrective action(s) accomplished for affected employee(s): The facility immediately reviewed the personnel files of employees E9, E10, E11, E12, E13, E14, and E15. Employees lacking required TB screening documentation were scheduled to go to the laboratory for QuantiFERON test to complete the acceptable QuantiFERON testing. Documentation was obtained and placed in personnel files. 2. How other employees having the potential to be affected were identified and corrected: This failed practice has the potential to affect all residents as identified by the resident census. 3. Systemic changes implemented to prevent recurrence: The facility revised its hiring and onboarding process to include a pre-employment QuantiFERON test to the Certiphi checklist which prevents moving forward with onboarding process in our online system until completed. No employee will be permitted to begin work until all required tuberculosis screening documentation has been received and verified. Executive Director re-educated management staff were regarding regulatory requirements. 4. Monitoring/Quality Assurance: The Executive Director and/or designee will conduct monthly audits of employee files for 3 months to verify compliance. Findings will be reported to the QA Committee. Any missing documentation identified will be corrected immediately.	Completed By: 7/10/2026 and ongoing.

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	facility lacked evidence of the second step TST. 2/4/26 – E11 (RA) was hired. A first step TST was performed. The facility lacked evidence of the second step TST being administered. 2/11/26 – E12 (RA) was hired. A first step TST was performed. The facility lacked evidence of the second step TST being administered. 3/11/26 – E13 (LC) was hired. A first step TST was performed. The facility lacked evidence of the second step TST being administered. 4/1/26 – E14 (RA) was hired. A first step TST was performed. The facility lacked evidence of the second step TST being administered. 5/27/26 8:40 AM – An interview with E9 (BOM) confirmed the facility lacked evidence of the second step TST being completed for E9, E11, E12, 13 and E14. E9 also confirmed lack of evidence of E15 not having any evidence of tuberculosis testing. E9 stated, "I can tell you that these employees did not have a second TST done and E15 was not tested." **Resident Assessment** **Each assisted living facility shall use a Uniform Assessment Instrument (UAI) developed by the Division. The UAI shall be used in conducting all resident assessments.** **The resident assessment shall be completed in conjunction with the resident.**		

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3225.11.0 **3225.11.1** **3225.11.4** **S/S – E**	**These requirements were not met as evidenced by:** Based on interviews, record review and review of other facility records it was determined for four (R1, R10, R11, R13) out of five residents reviewed for resident assessment the facility failed to ensure the Uniform Assessment Instrument (UAI) was signed and dated by the resident and/ or responsible person once completed. Findings include: 1. R1's clinical record revealed: 3/6/26 – R1 was admitted to the facility. 4/23/26 – A review of a UAI assessment for R1 a resident cognitively intact for a change of level of care had not been signed by the resident or the responsible person. 2. R10's clinical record revealed: 5/31/23 – R10 was admitted to the facility. 2/6/26 – R10 a resident on the Memory Care unit clinical record revealed a UAI assessment completed for a significant change had not been signed by the responsible person. 3. R11's clinical record revealed: 4/30/25 – R11 was admitted to the facility. 5/26/26 1:30 PM – R11 a resident on the Memory Care unit clinical record revealed a UAI assessment was completed for a significant change but was not signed or dated by the facility and/or the R11's responsible person.	**3225.11.0** 1. Corrective action(s) accomplished for affected resident(s): The Uniform Assessment Instruments (UAIs) for Residents R1, R10, R11, and R13 were reviewed. All identified deficient assessments were updated to ensure compliance with regulatory requirements. Nursing responsible for completion of UAIs received education regarding requirements for resident and/or responsible party signature completion. 2. How other residents having the potential to be affected were identified and corrected: This failed practice has the potential to affect all residents as identified by the resident census. 3. Systemic changes implemented to prevent recurrence: The Health Care Director and/or designees were educated regarding UAI regulatory requirements and documentation standards, by Executive Director. No UAI will be considered complete until all required signatures are obtained. 4. Monitoring/Quality Assurance: The Health Care Director or designee will audit new admissions, annual assessments, and significant change assessments weekly for 4 weeks and monthly thereafter for 3 months. Audit findings will be reviewed through the Quality Assurance program, and corrective action will be taken immediately if deficiencies are identified.	Completed By: 7/10/2026 and ongoing.

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	4. R13's clinical record revealed: 10/31/24 – R13 was admitted to the facility. 12/4/25 – R13 a resident on the Memory Care unit clinical record revealed a UAI assessment had not been signed by the responsible person. 5/26/26 1:45 PM – E2 (RDRC) confirmed the UAI assessments were not dated or signed by the facility or in conjunction with the resident and/or responsible persons as indicated. 5/27/26 10:30 AM – Findings were reviewed at the exit conference with E1 (ED) and E2 (RCRD). **Services** **The assisted living facility shall ensure that:** **Food service complies with the Delaware Food Code** **Delaware Food Code** 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: **Delaware Food Code 3-307.11 Miscellaneous Sources of Contamination: FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.** 5/20/26 – 11:30 AM - During the annual survey of the facility, the surveyor observed		
3225.12.0 **3225.12.1** **3225.12.1.3** **S/S - E**			

Provider's Signature [signature] Title Executive Director Date 6/2/26

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	a black plastic fork left inside a container of raw carrots in the server refrigerator located in the Memory Care Unit kitchenette. 5/20/2026 – 11:32 AM - During the annual survey of the facility, the surveyor observed a half roll of toilet paper placed on top of a rack located in the Memory Care Unit kitchenette. **Delaware Food Code 3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. (B) Label information shall include:(1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement;** 5/20/26 – 11:27 AM - During the annual survey of the facility, the surveyor observed a container appearing to contain ranch dressing without a common name of item and date labeled in the server refrigerator located in the Memory Care Unit kitchenette. **Delaware Food Code 4-101.11 Characteristics. Materials that are used in the construction of UTENSILS and FOODCONTACT SURFACES of EQUIPMENT may not allow the migration of deleterious substances or impart colors, odors, or tastes to FOOD and under normal use conditions shall be: (B) Durable, CORROSION-RESISTANT, and nonabsorbent;** 5/20/26 – 11:35 AM - During the annual survey of the facility, the surveyor observed brownish-colored spots, appearing to be	**3225.12.0** 1. Corrective action(s) accomplished for affected residents: The carrots were immediately discarded. The half roll of toilet paper was removed from the kitchenette food service area. The unlabeled food item was discarded. The rusted area on the handwashing sink was repaired or scheduled for replacement, and the missing ceiling tile in the main kitchen was replaced. 2. How other residents having the potential to be affected were identified and corrected: This failed practice has the potential to affect all residents as identified by the resident census. 3. Systemic changes implemented to prevent recurrence: Dietary staff were educated on Delaware Food Code requirements, by Dining Director, including food labeling, contamination prevention, equipment maintenance, and environmental sanitation standards. Executive Director implemented weekly environmental rounds to ensure compliance with food service regulations. Dietary staff received education regarding food safety, sanitation, labeling, and contamination prevention requirements. Dietary staff received education regarding maintenance issues communicating with maintenance through TELS work order. 4. Monitoring/Quality Assurance: The Dining Services Director and/or designee will conduct weekly food service audits for 4 weeks and monthly thereafter for 3 months. Audit findings will be reviewed at QA meeting. Any identified deficiencies will be corrected immediately, and staff re-education will be provided as necessary.	Completed By: 7/10/2026 and ongoing.

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	rust, along the edge of the handwashing sink located in the Memory Care Unit kitchenette. **Delaware Food Code 6-201.11 Floors, Walls, and Ceilings: 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.** 5/20/26 – 10:45 AM - During the annual survey of the facility, the surveyor observed a missing ceiling tile in the main kitchen located between the prep station and the serving area. **Service Agreements** **A service agreement based on the needs identified in the UAI shall be completed prior to or no later than the day of admission. The resident shall participate in the development of the agreement. The resident and the facility shall sign the agreement and each shall receive a copy of the signed agreement. All persons who sign the agreement must be able to comprehend and perform their obligations under the agreement.**		
3225.13.0 **3225.13.1** **S/S – E**	**These requirements have not been met as evidenced by:** Based on interviews, record review and review of other facility records it was determined for four (R1, R10, R11, R13) out of five residents reviewed for service agree-		

Provider's Signature [signature] Title Executive Director Date 6/2/26

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	ments the facility failed to ensure the service agreement was signed and dated by the resident and/or responsible person once completed. Findings include: 1. R1's clinical record revealed: 3/6/26 – R1 was admitted to the facility. 4/23/26 – A review of a service agreement for R1 a resident cognitively intact for a change of level of care had not been signed by the resident or the responsible person. 2. R10's clinical record revealed: 5/31/23 – R10 was admitted to the facility. 2/6/26 – R10 a resident on the Memory Care unit clinical record revealed a service agreement completed for a significant change had not been signed by the responsible person. 3. R11's clinical record revealed: 4/30/25 – R11 was admitted to the facility. 12/2/25 - R11 a resident on the Memory Care unit clinical record revealed a service agreement was completed for a significant change but was not signed or dated by the facility and not by R11's responsible person. 4. R13's clinical record revealed: 10/31/24 – R13 was admitted to the facility. 12/4/25 – R13 a resident on the Memory Care unit clinical record revealed a service agreement was not signed by the responsible person. 5/26/26 1:45 PM – During an interview, E2 (RDRC) confirmed the service agreements	**3225.13.0** 1. Corrective action(s) accomplished for affected resident(s): The service agreements for Residents R1, R10, R11, and R13 were reviewed. All identified deficient assessments were up-dated to ensure compliance with regulatory requirements. RN responsible for completion of service agreements and signatures. Nursing staff received education regarding requirements for resident and/or responsible party signature completion. 2. How other residents having the potential to be affected were identified and corrected: This failed practice has the potential to effect all residents as identified by the resident census. 3. Systemic changes implemented to prevent recurrence: The Executive Director will educate the nursing staff on the Move-in process and significant change procedures to ensure service agreements are reviewed, signed, and distributed in accordance with regulations. 4. Monitoring/Quality Assurance: The Health Care Director or designee will audit new and revised service agreements weekly for 4 weeks and monthly thereafter for 3 months. Results will be reviewed during QA meeting, and corrective actions will be implemented immediately for any identified concerns.	Completed By: 7/10/2026 and ongoing.

Provider's Signature [signature] Title Executive Director Date 6/11/26

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	were not dated or signed by the facility, resident and/or responsible party as required. E2 stated, "I don't understand why these weren't signed. They were printed for signature, but moving forward, they will be." 5/27/26 10:30 AM – Findings were reviewed at the exit conference with E1 (ED) and E2 (RCRD).		
	Staffing **Assisted living facility resident assistants shall have a minimum:** **Participate in a facility-specific orientation program that covers the following topics:** **Infection control, including Standard Precautions;** **The health and psychosocial needs of the population being served;**		
3225.16.0 **3225.16.14** **3225.16.14.2**	**16 Del.C. Ch. 11, pertaining to residents' rights; reporting of abuse, neglect, mistreatment, and financial exploitation; and Ombudsman Program;** **Receive, at a minimum, 12 hours of regular in-service education annually which may include but not be limited to the topics listed in 16.14.2;**		
3225.16.14.2.2			
3225.16.14.2.6	**The assisted living facility shall maintain records of each employee's regular in-service education hours.**		
3225.16.14.2.9	**The assisted living facility shall provide orientation training to all new staff.**		

Provider's Signature [signature] Title Executive Director Date 6/11/26

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3225.16.14.3 **3225.16.18** **3225. 16.19** **S/S –E**	**These requirements were not met as evidenced by:** Based on interview, record review and review of other facility documentation it was determined that for three (E16, E18 and E19) out of seven (7) resident assistants sampled for annual in-service training, the facility failed to ensure facility-specific training was completed. In addition, two (E16 and E17) resident assistants failed to complete 12 hours of in-service education annually. Findings include: 4/24/24 – E16 (RA) was hired. The facility lacked evidence of a minimum of 12 hours of annual training. Additionally, E16 lacked evidence of abuse and infection control training. 12/30/24 – E17 (RA) was hired. The facility lacked evidence of a minimum of 12 hours of annual training. 10/24/24 – E18 (DA) was hired. The facility lacked evidence that abuse training was completed. 11/8/24 – E19 (LH) was hired. The facility lacked evidence of abuse, dementia and infection control training was completed. 5/27/26 10:30 AM – Findings were reviewed at the exit conference with E1 (ED) and E2 (RCRD). **Records and Reports** **Reportable incidents shall be reported immediately, which shall be within 8 hours of**	**3225.16** 1. Corrective action(s) accomplished for affected employee(s): Employee files for E16, E17, E18, and E19 were reviewed. Missing orientation and annual in-service training requirements, including abuse prevention, infection control, dementia care, residents' rights, reporting requirements, and annual education hours, were completed or scheduled for immediate completion. Documentation of completed training placed in the employees' personnel files. 2. How other employees having the potential to be affected were identified and corrected: This failed practice has the potential to effect all residents as identified on the resident census. 3. Systemic changes implemented to prevent recurrence: The Community uses Relias as training platform for training and education for orientation requirements, annual education hours, and mandatory regulatory training topics. Management staff were educated regarding oversight responsibilities for employee training compliance for Relias, by Executive Director. 4. Monitoring/Quality Assurance: The Executive Director or designee will conduct monthly audits of employee training records for 3 months to verify ongoing compliance. Audit findings will be reviewed during QA meeting. Employees found to be non-compliant with training requirements will be scheduled for immediate remediation.	Completed By: 7/10/2026 and ongoing.

Provider's Signature _____ Title Executive Director Date 6/12/26

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DATE SURVEY COMPLETED: May 27, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225.19.0 3225.19.6 S/S – D	**the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.** **These requirements were not met as evidenced by:** Based on record review, interviews and a review of other facility documentation, it was determined that for two (R9 and R10) out of ten residents reviewed for facility-reported incidents, the facility failed to submit a follow-up report to the State Agency (SA) within the five-day timeframe. Findings include: 1. 9/10/25 – R9 was admitted to the facility. 10/29/25 4:39 PM – A facility-incident report documented that R9 was found on the floor in her room, an assessment was completed, and R9 was sent to the hospital. 12/17/25 12:11 PM – The facility submitted their 5-day follow-up to the SA. 5/22/26 3:30 PM - During an interview, E1 (ED) confirmed that the five-day follow-up was submitted late and that the facility did not follow protocol. E1 stated she does not know why the follow-up was submitted to the SA late. 2. R10's clinical record revealed: 5/31/23 – R10 was admitted to the facility. 1/31/26 8:45 PM – A review of a facility-reported incident to the SA documented, "Memory Care resident presented with sundowning behaviors into the evening.	**3225.19.6** 1. Corrective action(s) accomplished for affected resident(s): The incidents involving Residents R9 and R10 were reviewed to ensure all required documentation and follow-up reports are completed and submitted to the State Agency timely by implementing a Tracking log report. The RDO educated the management team regarding the requirements for reporting reportable incidents and submitting required follow-up reports within the prescribed timeframe. 2. How other residents having the potential to be affected were identified and corrected: This failed practice has the potential to affect all residents as identified by the current resident census 3. Systemic changes implemented to prevent recurrence: The facility implemented an Incident Reporting Tracking Report that documents the date and time of occurrence, date and time of initial reporting, due date for follow-up reporting, and submission completion date. Healthcare Director to review all reportable incidents. New Healthcare Director to be educated on Delaware reporting requirements and timelines, by Executive Director. 4. Monitoring/Quality Assurance: The Executive Director or designee will review reportable incidents weekly for 4 weeks and monthly for 3 months to ensure timely reporting and follow-up submissions. Audit results will be presented at QA meeting. Any identified reporting deficiencies will be addressed immediately.	Completed By: 7/10/2026 and ongoing.

Provider's Signature [signature] Title Executive Director Date 6/26/26

NAME OF FACILITY: Harmony at Kent

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	The resident became aggressive verbally and physically towards staff and two other Memory Care residents." 3/15/26 3:23 PM – The facility's five-day follow-up report was submitted to the State agency. 5/20/26 2:45 PM – During an interview, E1 (ED) confirmed the five-day follow-up report was not submitted timely. E1 stated, "I do know that the follow-up was late; there's no more than I can say about that." 5/27/26 10:30 AM – Findings were reviewed at the exit conference with E1 (ED) and E2 (RCRD). **Reportable incidents include:** **Abuse as defined in 16 Del.C. §1131.** **Physical Abuse** **Resident to resident with or without injury.** **This requirement was not met as evidenced by:**		
3225.19.7 **3225.19.7.1** **3225.19.7.1.1** **3225.19.7.1.1.2**	Based on interview, record review and a review of other facility documentation, it was determined for one (R10) out of ten residents reviewed for facility-reported incidents, the facility failed to report to the State Agency within the required 8 hours. Findings include: R10's clinical record revealed: 5/31/23 – R10 was admitted to the facility. 1/31/26 8:45 PM – A facility-reported incident documented, "Memory Care resident		

Provider's Signature [signature] Title Executive Director Date 6/1/26

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	[R10] presented with sundowning behaviors into the evening. The resident became aggressive verbally and physically towards staff and two other Memory Care residents." 2/2/26 2:18 PM – The facility submitted a facility-reported incident to the State agency for R10. 2/2/26 4:09 PM – A progress note authored by E2 (RDRC) documented "Was informed that over the weekend another resident and [R10] had an altercation of some kind. There were no reported injuries or complaints. [R10] presented well today with no complaints and still not remembering the incident. 5/20/26 2:45 PM – During an interview, E1 (ED) confirmed the initial incident report was not submitted within 8 hours. E1 stated, "I was not aware of the incident until the date that I reported it to the SA." 5/27/26 10:30 AM – Findings were reviewed at the exit conference with E1 (ED) and E2 (RCRD).	**3225.19.7** 1. Corrective action(s) accomplished for affected resident(s): The incident involving Resident R10 was reviewed to ensure all required documentation and follow-up reports are completed and submitted to the State Agency timely by implementing a Tracking log report. The RDO educated the management team regarding the requirements for reporting reportable incidents and submitting required follow-up reports within the prescribed timeframe. 2. How other residents having the potential to be affected were identified and corrected: This failed practice has the potential to affect all residents as identified by the current resident census 3. Systemic changes implemented to prevent recurrence: The facility implemented an Incident Reporting Tracking Report that documents the date and time of occurrence, date and time of initial reporting, due date for follow-up reporting, and submission completion date. Healthcare Director to review all reportable incidents. New Healthcare Director to be educated on Delaware reporting requirements and timelines, by Executive Director. 4. Monitoring/Quality Assurance: The Executive Director or designee will review reportable incidents weekly for 4 weeks and monthly for 3 months to ensure timely reporting and follow-up submissions. Audit results will be presented at QA meeting. Any identified reporting deficiencies will be addressed immediately.	Completed By: 7/10/2026 and ongoing.

Provider's Signature [signature] Title Executive Director Date 6/11/26

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 Kent

DATE SURVEY COMPLETED: May 27, 2026

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Provider's Signature [signature] Title Executive Director Date 6/21/26