DELAWARE HEALTH AND SOCIAL SERVICES

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

DHSS - DHCQ
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STATE SURVEY REPORT

NAME OF FACILITY: Harbor Chase of Wilmington

DATE SURVEY COMPLETED: July 24, 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 July 21, 2026, to July 24, 2026. The facility census on the entrance day of the survey was one hundred four (104) residents. The survey sample was composed of twelve (12) residents and a subsample survey of an additional two (2) residents. The survey process included observations, interviews, review of resident clinical records, facility documents and facility policies and procedures, and complaint and incident documentation from the State Agency. Abbreviations/definitions used in this state report are as follows: DOH – Director of Hospitality; DRC - Director of Resident Care; ED – Executive Director; EMR – Electronic Medical Record; LPN -Licensed Practical Nurse; NP – Nurse Practitioner; PA – Physician Assistant; PDC – Private Duty Companion; RN – Registered Nurse.	**Section: 3225.9.6** Flu vaccine **1. Corrective action(s) will be accomplished for residents found to have been affected by deficient practice?** R 2 refused the flu vaccine at the annual flu vaccine clinic. His POA has been notified ad it has been documented in his medical record.. 2. **How will other residents be identified who have the potential to be affected by the same practice and what corrective actions will be taken?** An audit of the 2025 flu clinic records showed that R2 was the only one who refused the administration of the vaccine. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur.** Nurses were re-inserviced on the need for documentation and POA notification of any resident refusing the annual flu vaccine. If a resident refuses to have the flu vaccine administered at the time of the Flu clinic, AL residents will be given a declination form to sign or if the resident resides in memory care their POA will be notified. A progress note will be written in the resident's medical record regardless of location. The DON or designee will audit the clinic worksheets within a week of the clinic to assure the refusal was correctly documented, that the POA notified as appropriate, and the clinical record reflects the refusal.	8/18/26
3225.0 3225.1.0	**Assisted Living Facilities** **Purpose** **The Department of Health and Social Services is issuing these regulations to promote and ensure the health, safety, and well-being of all residents of assisted living facilities. These regulations are also meant to ensure that service providers will be accountable to their residents and the Department, and to differentiate assisted living care from skilled nursing care. The essential nature of**		8/18/26

Provider's Signature _____ Title NHA/ED Date 8/20/26

NAME OF FACILITY: Harbor Chase of Wilmington

DATE SURVEY COMPLETED: July 24, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	assisted living is to offer living arrangements to medically stable persons who do not require skilled nursing services and supervision. The regulations establish the minimal acceptable level of services for residents of assisted living facilities.	**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur (Quality Assurance program)?**	
3225.9.0	**Infection Control**	Monthly review of vaccine compliance at QAA will specifically include acknowledgement by inspection DOW, ED or designee that physical vaccine record or documented declination is on file. Audit in QAA will be maintained for 3 months or until 100% compliance is achieved and reported to QAA committee. Audit will include all move-ins (total sample) monthly requiring 100% for those 3 months.	Ongoing
3225.9.6	**The assisted living facility shall have on file evidence of annual vaccination against influenza for all residents, as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against influenza must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.**	The flu vaccination refusals and chart audit will be reviewed at the QPAI meeting following the flu clinic.	
S/S – D	This requirement was not met as evidenced by: Based on record review, interview and review of other facility and State documentation, it was determined that for two (R2 and R4) out of twelve sampled residents, the facility failed to provide evidence of the 2025 influenza vaccine or a declination of such. Findings include: 1. 6/2/23 - R2 was admitted to the facility. There was no evidence of a 2025 influenza vaccination or a declination of such. 7/24/26 8:30 AM – During an interview, E3 (RN) stated R2 declined the vaccine when offered in 2025. E3 stated the documentation of the declination was not in evidence.	Schedule FLU Clinic with pharmacy: • May additionally offer PNA, RSV, COVID boosters as recommended by provider/CDC. • Provide resident education and 'call em all' with clinic information: • Front lobby/Concierge- should have copy of VIS for resident / responsible party if requested to review and posted information about vaccine clinic 1. Assist with obtaining resident consent forms (may use pharmacy forms, attached general flu consent for HRA) 2. Maintain a copy of consent/receipt in resident chart and update in YARDI under immunizations once vaccinations complete	

Provider's Signature [signature] Title DHA / ED Date 8/30/26

NAME OF FACILITY: Harbor Chase of Wilmington

DATE SURVEY COMPLETED: July 24, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	2. 10/6/25 - R4 was admitted to the facility. There was no evidence of a 2025 Influenza vaccination or a declination of such. 7/24/26 8:30 AM – During an interview, E3 (RN) stated R4's vaccine documentation was not in evidence. 7/24/26 - Findings were reviewed with E1 (ED) and E2 (DRC) at the exit conference, beginning at approximately 12:50 PM.	Concord Pharmacy: Flu Clinic Set for 10/27/26 at 1pm , per Drugxpert74@yahoo.com , IN October names of residents will be collected at least a week prior and sent back to pharmacy , target date 10/4/26 for consent(s) and declination(s) **ADDENDUM - A** Section: **3225.11.3** Resident Assessment	Ongoing
3225.11.0 **3225.11.3** **S/S – D**	**Resident Assessment** **Within 30 days prior to admission, a prospective resident shall have a medical evaluation completed by a physician.** This requirement was not met as evidenced by: Based on record review and review of other facility documentation, it was determined that for one (R12) out of twelve sampled residents, the facility failed to provide evidence that the physician's medical evaluation was within thirty days prior to admission. Findings include: 4/28/26 – R12 was admitted to the facility. 4/6/26 - The medical evaluation form was signed by the physician. On review of the evaluation, the physician noted the examination visit date was on 2/3/26, greater than the 30-days prior to admission.	**1. Corrective action(s) will be accomplished for residents found to have been affected by deficient practice** Nothing can be done for R12's doctor visit more than 30 days prior to admission. **2. How will other residents be identified who have potential to be affected by the same practice and what corrective actions will be taken ?** The direction of Sales will audit the admission doctor paperwork for any admission within the last 30 days to identify any resident who may have not been seen by the physician within 30 days of admission. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Sales (DOS) were reinserviced by the ED or designee about the need to have proof of a preadmission doctor visits within 30 days prior to admission. **4. How the corrective action(s) will be monitored to ensure the deficient**	7/29/26

Provider's Signature _____ Title NHA/ED Date 8/20/26

NAME OF FACILITY: Harbor Chase of Wilmington

DATE SURVEY COMPLETED: July 24, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	7/24/26 - Findings were reviewed with E1 (ED) and E2 (DRC) at the exit conference, beginning at approximately 12:50 PM.	**practice will not recur (Quality Assurance program) ?** Due to the volume of potential move-ins and greater sample size The ED or designee will audit new admission paperwork to assure documentation of a doctor visit within 30 days of all new admission daily x 30 days then weekly x 3 and monthly x1 until 100 % compliance is achieved. *Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits and adjusted according to outcomes.* ADDENDUM - B **3225.12.13** **Food Service** **Corrective action(s) will be accomplished for residents found to have been affected by deficient practice?** **1. How will other residents be identified who have the potential to be affected by the same practice and what corrective actions will be taken?** These indicated areas were the only ones identified at survey and time of correction. Executive Director walked through and inspected with surveyor no other deficiencies identified. **2. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur.**	Ongoing 7/28/26
3225.12.0	**Services**		
3225.12.1	**The assisted living facility shall ensure that:**		
3225.12.13	**Food service complies with the Delaware Food Code**		
S/S – F	**Delaware Food Code** **4-6 CLEANING OF EQUIPMENT AND UTENSILS** **4-601.11 Equipment, Food-Contact Surfaces, Nonfood- Contact Surfaces, and Utensils.** **(C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.** This requirement was not met as evidenced by: Based on observations it was determined that the facility failed to comply with the Delaware Food Code. Findings include: 7/23/26 11:00 AM - During the survey of the facility kitchen, it was observed that excessive debris and plastic food containers were located under the preparation table and under the stove. 7/23/26 – Findings were reviewed with E1 (ED) and E5 (DOH) at approximately 11:30 PM.		

Provider's Signature _____ Title NHA/ED Date 8/30/26

NAME OF FACILITY: Harbor Chase of Wilmington

DATE SURVEY COMPLETED: July 24, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225.14.0 3225.14.1 S/S – D	**Resident Rights** **Assisted living facilities are required by 16 Del.C. Ch. 11, Subchapter II, to comply with the provisions of the Rights of Patients covered therein.** **(81 Del. Laws, c. 206, § 23.)** **§ 1121. Resident's rights.** **(b) It is declared to be the public policy of this State that the interests of the resident shall be protected by a declaration of a resident's rights, and by requiring that all facilities treat their residents in accordance with such rights, which shall include the following:** **(1) Each resident shall have the right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.** **(13) Each resident shall receive care that meets professional standards of care.** This requirement was not met as evidenced by: Based on record review, interviews, review of other facility, hospital and State documentation, it was determined that for one (R8) out of fourteen sampled residents for falls, the facility failed to notify R8's POA of a change in condition, thereby not providing a professional standard of care for a resident with dementia. Findings include:	Executive Chef and Hospitality Dining Room Manager were in-serviced on basic expectations of health sanitation and cleanliness (overall kitchen cleanliness) and will continue to manage through policy and procedure. **3. How the corrective action(s) will be monitored to ensure the deficient practice will not recur (Quality Assurance program)?** Hospitality Checklist(s) have incorporated cleanliness standards and will be utilized for QAA purposed. Executive Director may also along with designee as appropriate inspect randomly during and after mealtimes. **Addendum E** **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur (Quality Assurance program) ?** Cleaning and hospitality checklists will be provided at time of monthly QAA and evaluated at quarterly for ongoing compliance. At minimum random checks (via checklist) will be made weekly on various mealtimes and times of day included but not limited to end of day close. At minimum monthly review will include 4-5 checklists. Executive Director inspections will not be included in this monitoring. Findings will be reported during the monthly QAPI meeting for review and recommendations until 100% compliance is achieved for three months. The frequency of the audits and adjusted according to outcomes.	

Provider's Signature _____ Title NHA/EA Date 8/30/26

NAME OF FACILITY: Harbor Chase of Wilmington

DATE SURVEY COMPLETED: July 24, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	1/12/24 – R8 was admitted to the facility in the memory care unit with diagnoses of dementia and history of falls. 1/14/26 4:27 AM - Per EMR entry by E30 (LPN) noted R8 was calling for assistance at 2:45 AM and "found sitting on her bedroom floor next to the nightstand." R8 "reported back and shoulder pain" and was given oxycodone with relief. 1/14/26 3:59 AM – PA1 performed a virtual exam via telehealth and determined R8 noted her fall striking bedroom furniture with mid-back and left shoulder pain. PA1 noted no changes in vital signs, including unlabored respiratory effort and a full range of motion of left shoulder. Skin assessment per staff was warm, dry with no rashes or lesions. There was no mention of any bruising in evidence. PA1 indicated to continue supportive care. 1/14/26 3:40 PM – Per EMR entry by E29 (LPN), R8 complained of midback and left shoulder pain. R8 was given oxycodone with relief. E29 noted that NP1 ordered a thoracic/spine x-ray at 10:00 AM but had not been completed as of 3:00 PM. 1/14/26 3:40 PM - per EMR entry E2 noted that the POA was not notified of the fall or the post-fall plan of care. 1/15/26 11:30 AM – per EMR entry by E2 (DRC), R8's PDC (private duty companion) relayed to nurse that R8 was complaining of pain to her left hip and shoulder. E2 noted bruising was present. E2 noted that F1 called and requested R8 be transferred to the ER	Section: **3225.14. Resident Rights** **1. Corrective action(s) will be accomplished for residents found to have been affected by deficient practice** Nothing can be done for those resident(s) R8 who were not notified timely. **2.How will other residents be identified who have potential to be affected by the same practice and what corrective actions will be taken ?** An audit of the incident reports for the past 30 days was conducted by the DRC or designee to assure an RN assessment occurred. Nothing can be done for those residents who were not notified however of the 30 day audit no additional incidents were found. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur?** Nurses re-Inserviced on reportable incident(s) and family/physician notification. More specific content training on specificity of fall(s) in regards to falls and assessment (next citation) In-service combined. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur (Quality Assurance program) ?**	8/1/26 8/18/26

Provider's Signature _____ Title NHA/BA Date 8/10/26

NAME OF FACILITY: Harbor Chase of Wilmington

DATE SURVEY COMPLETED: July 24, 2026

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	for evaluation. R8 was transferred via 911 to the hospital at 11:15 AM. The hospital record indicated R8 suffered from a laceration of the spleen, multiple rib fractures, lumbar spinal fractures and a left pleural effusion. 7/24/26 10:20 AM - In a telephone interview with F1, F1 confirmed she was not notified by the facility staff of R8's fall. F1 stated she received a call from the PDC with pictures of the bruising post-fall which appeared substantial. F1 stated she called the facility and asked the staff to transfer R8 to the hospital. 7/24/26 12:40 PM – E2 confirmed the daughter was not called about R8's fall and that F1 did request R8 be transferred to the hospital since the x-ray had not been performed by that time. E2 stated that NP1 was going to see R8 once the x-ray was completed. R8 stated the x-ray staff came shortly after R8 was transferred. 7/24/26 - Findings were reviewed with E1 (ED) and E2 at the exit conference, beginning at approximately 12:50 PM.	Findings will be reported during the monthly QAPI meeting for review and recommendations until 100% compliance is achieved for three months. The frequency of the audits and adjusted according to outcomes. Monthly all incident reports indicated will be compared from 24 hour report, to Yardi interface and Wellsky if transfer to higher level of care or injury indicated as well as notification to physician/family. Sample will include entirety of incident reports. Should the entirety of those 4 indicator points not concur the 3 month (90 day) audit period will continue until compliance (100%) met. **Addendum C1** **3225.16.** Staffing **1. Corrective action(s) will be accomplished for residents found to have been affected by deficient practice** Nothing can be done for those residents who do not have an RN assessment documented. **2. How will other residents be identified who have potential to be affected by the same practice and what corrective actions will be taken ?** An audit of the incident reports for the past 30 days will be conducted by the DRC or designee to assure an RN assessment oc-	Ongoing 8/1/26
3225.16.0 3225.16.2 S/S – D	**Staffing** **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.** **State Of Delaware Board of Nursing- "RN (registered nurse), LPN (licensed practical nurse) and NA (nurse's aide)/ UAP (unlicensed assistive personnel) Duties**		

Provider's Signature _____ Title NHA/ED Date 8/30/26

NAME OF FACILITY: Harbor Chase of Wilmington

DATE SURVEY COMPLETED: July 24, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	2024...Post Fall Assessment & Documentation- RN..." Updated 4/10/24. This requirement was not met as evidenced by: Based on record review, interview and review of other facility and State documentation, it was determined that for two (R2 and R5) out of fourteen sampled residents for falls, an LPN (not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice) completed a resident's post fall assessment. Findings include: 1. 6/2/23 – R2 was admitted to the facility. A review of R2's fall incident revealed the following post-fall assessment was completed by an LPN, not an RN as required by the Delaware State regulation of the Board of Nursing. - 5/18/26 at 6:15 AM. There was no evidence the staff attempted to schedule a telehealth assessment or an RN evaluation. 2. 6/30/25 – R5 was admitted to the facility. A review of R5's fall incident report revealed the following post-fall assessment was completed by an LPN, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. - 3/8/26 at 12:55 AM. Per the EMR entry, there was an attempt by E30 (LPN) to notify SHC (Seniority Health Care) to perform a telehealth visit, however SHC stated R5 was not in their system, so they were unable to do the telehealth visit. E30 notified E2 (DRC) of the fall who requested that R5 be transferred to the hospital for evaluation.	curred. Nothing can be done for those residents who do not have an RN assessment documented. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur?** Nurses were re-Inserviced that an in-person RN or telehealth RN or higher assessment must be documented in the clinical record or on the incident report when a resident does not require transfer to a higher level of care after a fall. The DRC or designee will audit each incident report to determine that the RN assessment has been documented in the incident report or clinical record weekly x4 and monthly x2. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur (Quality Assurance program) ?** Findings will be reported during the monthly QAPI meeting for review and recommendations until 100% compliance is achieved for three months. The frequency of the audits and adjusted according to outcomes. Audit reporting to include prior deficiency (notification) in addition to documentation of RN Assessment for all falls. Monthly all incident reports indicated will be compared from 24 hour report, to Yardi interface and Wellsky if transfer to higher level of care or injury indicated as	8/18/26 Ongoing

Provider's Signature _____ Title NHA/ED Date 8/10/26

NAME OF FACILITY: Harbor Chase of Wilmington

DATE SURVEY COMPLETED: July 24, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	R5's daughter refused to have her mom transferred to the ER. There was no evidence that an RN assessment post-fall was then completed. 7/23/26 3:30 PM – During an interview, E2 (DRC) stated the facility and SHC group have a contract to complete post-fall assessments via telehealth. E2 stated that at one point, the SHC clinician that was called at the time of the fall found that the resident was "not in their system" and declined to provide the assessment. E2 stated that was addressed and corrected so even when a resident is not on the SHC group's service, they will perform the post-fall assessments. 7/24/26 - Findings were reviewed with E1 (ED) and E2 at the exit conference, beginning at approximately 12:50 PM.	well as notification to physician/family. Sample will include entirety of incident reports. Should the entirety of those 4 indicator points not concur the 3 month (90 day) audit period will continue until compliance (100%) met. **Addendum C2** **3225.19** Record and Reports Neglect **1. Corrective action(s) will be accomplished for residents found to have been affected by deficient practice**	
3225.19.0 3225.19.6 S/S – D 3225.19.7 3225.19.7.2	**Records and Reports** **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.** **Reportable incidents include:** **19.7.2 Neglect as defined in 16 Del.C. §1131.** **(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.**	No further correction can be made – post compliance noted in survey **2. How will other residents be identified who have potential to be affected by the same practice and what corrective actions will be taken ?** No other residents were impacted by the isolated incident and correction made immediately. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur?**	**5/7/2026**

Provider's Signature _____ Title NHA/ED Date 8/30/26

NAME OF FACILITY: Harbor Chase of Wilmington

DATE SURVEY COMPLETED: July 24, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	This requirement was not met as evidenced by: Based on a review of medical records, interviews and the facility and the Division documentation, it was determined that for one (R4) out of twelve residents sampled for reportable incidents, the facility failed to report neglect per the State regulation. Findings include: 10/6/25 – R4 was admitted to the facility in the memory care unit. 4/30/26 –The facility camera footage review revealed that R4 was left outside for three and one half hours (two and one half hours without supervision). R4 sustained sunburn. Once it was discovered that R4 was outside, she was returned inside, assessed and provided lunch and hydration. 7/24/26 12:40 PM - per interview with E1 (ED), E1 stated the employee was suspended and subsequently terminated from employment. The facility provided re-education, review of and implementation of revised safety measures to memory care caregivers and activity personnel. The employee termination, the re-education provided on resident care when outside, and the procedure revision and education were reviewed and confirmed as completed by the surveyor. Facility met compliance as of May 7, 2026. 7/24/26 - Findings were reviewed with E1 and E2 (DRC) at the exit conference, beginning at approximately 12:50 PM. This is a past non-compliance	Corrective action was taken regarding the lack of attention to sun exposure. Information shared at time of survey and indicated as meeting post compliance 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (Quality Assurance program) ?** Findings were reported during the monthly QAPI meeting for review and recommendations until 100% compliance was achieved for three months. QAA/Best Practices implemented were shared at time of annual and complaint survey including inventory of sun bonnets, sunscreen as well as assignment checklists and monitoring of hydration stations. Additional umbrellas were added for shading in memory care courtyard. **Past non-compliance**	**5/7/26**

Provider's Signature _____ Title NHA/ED Date 8/20/26