DELAWARE HEALTH AND SOCIAL SERVICES

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

DHSS - DHCQ
263 Chapman Road, Suite 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: The Pointe at South Harmony Place **DATE SURVEY COMPLETED:** February 4, 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 February 2, 2025, through February 4, 2025. 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 twenty-nine (29). The survey sample totaled six (6) residents. Abbreviations/definitions used in this report are as follows: BOM – Business Office Manager; CRD – Community Resource Director; CSD – Clinical Specialist District; ED - Executive Director; FD – Facilities Director; FSD – Food Services Director; HSD – Health Services Director; LPN – Licensed Practice Nurse; MD – Maintenance Director; MA – Medication Assistant; NP – Nurse Practicioner; RA – Resident Assistant; RN – Registered Nurse.		
3225. **3225.11.0** **3225.11.3** **S/S – D**	**Assisted Living Facilities** **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, interview, and review of other facility documentation, it was determined that for one (R5) out of two res-	**3225.11.0** 1. There were no residents negatively impacted by deficient practice. The facility will ensure that nursing services meet professional standards by obtaining Physicians, medical evaluation prior to admission, to meet the standards of practice. 2. All residents have the potential to be affected by this deficient practice.	3/15/2026

Provider's Signature _____ Title ED Date 2/27/26

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	idents sampled for pre-admission assessments, the facility failed to provide evidence of the Physician's medical evaluation prior to admission. Findings include: 6/27/25 – R5 was admitted to the facility. The Physician's evaluation was completed on 7/21/25, after R5's admission. 2/4/26 - Per interview with E2 (HSC) at approximately 12:40 PM, E2 confirmed the resident's record did not include the Physician's evaluation prior to the residents' admission. 2/4/26- Findings were reviewed with E1 (ED), E2, E3 (BOM/HR), E5 (MD) and E18 (CRD) at the exit conference, beginning at approximately 12:45 PM.	3. All staff included in the admission process will be in-serviced by the HSD no later than 3/15/26. 4. The HSD or designee will perform a full house audit to ensure preadmission documentation is on file. New preadmission assessments will be verified for completion weekly X 4 weeks. Biweekly x 4 Weeks. Monthly x 1 month until 100% compliance is reached.	
3225.12.0 **3225.12.1** **3225.12.1.3** **S/S – F**	**Services** **The assisted living facility shall ensure that:** **Food service complies with the Delaware Food Code** **Delaware Food Code:** **Chapter 6 Physical Facilities** **6-5 MAINTENANCE AND OPERATION** **6-501 Premises, Structures, Attachments, and Fixtures – Methods** **6-501.14 Cleaning Ventilation Systems, Nuisance and Discharge Prohibition. (A) Intake and exhaust air ducts shall be cleaned and filters changed so they are not a source of contamination by dust, dirt, and other materials.** Based on observations and interview, it was determined that the facility failed to comply		

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	with the Delaware Food Code. Findings include: 2/3/26 10:30 AM - During the survey of the facility, an observation of the kitchen revealed dusty vents in the ceiling. During an interview with E4 (FSD) during the facility tour, E4 confirmed the findings. 2/3/26 – Findings were reviewed with E1 (ED) at approximately 3:30 PM.	**3225.12.1** 1.There were no residents negatively impacted by the deficient practice. The FD will ensure that all cleaning of the ventilation Systems, Nuisance and Discharge Prohibition. (A) Intake and exhaust air ducts will be cleaned, and filters are changed, so they are not a source of contamination by dust, dirt, and other materials to comply with the Delaware Food Code. FD will have all vents cleaned in the kitchen 2. All residents have the potential to be affected by this deficient practice 3. ED will in service the FD and FSD on the importance of making sure that all equipment including the vents are cleaned and in working condition by 3/15/26. 4. The FSD or designee will perform audits of the kitchen and vents weekly X 4 weeks. bi-weekly x 4 weeks. Monthly x 1 month until 100% compliance is reached.	3/15/2026
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 2024...Post Fall Assessment & Documentation- RN..." Updated 4/10/24.** This requirement was not met as evidenced by: Based on record review and other facility documentation including incident reports, it was determined that one (R3) out of six residents reviewed, the facility failed to ensure that nursing services met professional standards as evidenced by having LPNs complete the post fall assessment for residents, which violates the Delaware State Board of Nursing Scope of Practice. Findings include: 2/2/24 - R3 was admitted to the facility.		

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	9/25/25 9:05 PM – Per medical record review, E19 (LPN) documented that R3 sustained an unwitnessed fall. E19 noted the "RN notified". The medical record lacked evidence that R3 was evaluated by an RN after this fall. The post fall assessment was completed by E19, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 2/4/26- Findings were reviewed with E1 (ED), E2(HSD), E3 (BOM/HR), E5 (MD) and E18 (CRD) at the exit conference, beginning at approximately 12:45 PM.	**3225.16.0** 1.There were no residents negatively impacted by the deficient practice. The facility will ensure nursing services meet professional standards by having the RN's complete and document Resident post fall assessment to stay in compliance with the Delaware State Board of Nursing Scope of Practice. 2. All residents have the potential to be affected by this deficient practice. 3. All Nursing staff will be in-serviced by HSD no later than 3/15/26. 4. The HSD or designee will perform Post Fall documentation by RN Audits. Completed weekly X 4 weeks. Biweekly x 4 Weeks. Monthly x 1 month until 100% compliance is reached.	3/15/2026
3225.18.0 **3225.18.3** **S/S - F**	**Emergency Preparedness** **Each facility shall develop and maintain all-hazard emergency plans for evacuation and sheltering in place. The plan must be submitted to the Division and DEMA in a digital format and it must conform to the template prescribed by the Division. The all-hazard emergency plan must include plans to address staffing shortages and facility demands.** Based on documentation review and interviews, it was determined that the facility failed to address facility demands in their emergency operations plan (EOP) when the facility contacts were not current. Findings include: 2/3/26 1:00 PM – During the survey of the facility, the review of the EOP revealed the contact information for the Executive Direc-		

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	tor and the Facilities Director who are involved in carrying out the plan were incorrect. 2/3/26 – Another emergency contact list was provided by E1 (ED) at approximately 1:30 PM which also reflected incorrect names for the Executive Director and the Facilities Director. 2/3/26 – Findings were reviewed with E1 at approximately 3:30 PM.		
Title 16 Delaware Code Chapter 11 Subchapter II. Rights of Residents **S/S- D** **Sub-chapter III Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents. (81 Del. Laws, c. 206, § 31; 83 Del.**	**1121 Resident Rights (13) Each resident shall receive care that meets professional standards of care.** **(12) "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.** **Neglect includes all of the following:** **a. Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety.** This requirement was not met as evidenced by: Based on record review, interview, employee file review, review of other facility documentation and incident documentation from the State Agency, it was determined that for one (R5) out of six sampled residents	**3225.18.3** 1.There were no residents negatively impacted by the deficient practice. The FD will develop all-hazard emergency plans for evacuation and sheltering in place. The plan will be submitted to the Division and DEMA in a digital format and will conform to the template prescribed by the Division. The all-hazard emergency plan will include plans to address any staffing shortages and facility demands. 2. All residents have the potential to be affected by this deficient practice 3. ED will in service the FD on the importance of making sure the EOP is updated with current information no later than 3/15/26. 4. The FD or designee will perform audits of the EOP binder weekly X 4 weeks. biweekly x 4 weeks. Monthly x 1 month until 100% compliance is reached.	3/15/2026

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Laws, c. 22, § 1.)	reviewed for accidents, the facility failed to ensure appropriate safety measures were provided during transport. Findings include: 6/27/25 – R5 was admitted to the facility. 11/25/25 – Per medical record documentation and the facility's reporting to the State Incident Reporting System, R5 was being transported by the facility's vehicle to a medical appointment. E21 (Ex-Driver) went over a bump in the road at 12:45 PM and R5 fell from her wheelchair to the vehicle floor. E21 and E22 (RA/MA) assisted her off of the floor and offered to transport R5 to the ER for evaluation in which R5 declined. On return to the facility at 2:20 PM, R5 complained to E20 (LPN) of left side head and right ankle pain and noted a bump on her head. E22 documented that R5 stated the seatbelt and wheelchair locks were in place on her return but later stated the seatbelt was not secured during the earlier transport. The NP assessed R5 and x-rays of her right ankle were ordered. With staff and family encouragement, R5 later consented to be transferred to the ER for evaluation at 4:40 PM. Per x-ray results and the ER record, there were no acute injuries noted and R5 was returned to the facility on 11/26/25 at 10:15 AM. 2/3/26 1:55 PM – Per interview with E1 (ED), E1 stated that both E21 and E22 were suspended because of the delayed reporting of the incident to E2 (HSD) which was approximately two hours later and pending investigation.		

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	Per E1's statement, E21 was sent for alcohol and drug testing on 11/25/26. E21's drug results were received on 12/8/25 with positive results, and E21's employment was terminated on 1/2/26. E1 was unsure of E21's safety training at hire as no documentation of such could be located. E1 stated the investigation indicated that the wheelchair was locked in, but there were conflicting stories regarding the seatbelt being secured. E1 stated that E5 (MD) examined the vehicle's seatbelt and found it to be in working order. 2/4/26 – Per review of facility documentation of staff in-services regarding incidents and reporting and the facility's implemented safety training for drivers, the facility was found to be in compliance with correcting this deficiency. Completion date – 1/2/26. 2/4/26- Findings were reviewed with E1, E2, E3 (BOM/HR), E5 and E18 (CRD) at the exit conference, beginning at approximately 12:45 PM.	**Past Non – Compliance**	

Provider's Signature Josephine Rosato Title ED Date 2/27/26

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