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: AL - Harbor Chase of Wilmington

DATE SURVEY COMPLETED: January 2, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Follow up survey to the Complaint survey ending November 7, 2025, was conducted at this facility from December 1, 2025, through January 2, 2026. The deficiency contained in this report is based on observation, interview, record review and review of other facility documentation as indicated. The facility census on the first day of survey was ninety – six (96). The survey sample was composed four (4) residents. Abbreviations/definitions used in this state report are as follows: Dementia – brain disorder with memory loss, poor judgment, personality changes and disorientation. DMC – Director of Memory Care; DRC – Director of Memory Care; ED – Executive Director; LPN – Licensed Practical Nurse; MC – Memory Care; RN – Registered Nurse.		
3225.0 **Title 16** **Sub Chapter II Rights of Residents**	**Resident's Rights** **1121 Resident Rights** **(13) Each resident shall receive care that meets professional standards.**		
3225.8.0	**Medication Management**		

Provider's Signature Steven Yohey Title Executive Director Date 2/16/26

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3225.8.8.2 S/S – E	**Each resident receives the medications that have been specifically prescribed in the manner that has been ordered.** Based on observation, interview, record review and review of other facility documentation, it was determined that for one (R3) out of four residents sampled for medication administration, the facility failed to ensure that R3's medications were administered per the physician's orders. Findings include: 2/6/19 – R3 was admitted to the facility with diagnoses including dementia with severe agitation. 2/17/25 – R3 was admitted to hospice services. 12/22/25 – R3 had a new physician's order for oxycodone 5 mg 1 tablet by mouth every three (3) hours for pain post fall with a broken pelvic bone. 12/31/25 – A review of R3's Medication Administration Record (MAR) from 12/19/25 through 12/31/25 revealed missing oxycodone 5 mg doses indicating the reason "Med Not Available" on all missing entries: Oxycodone 5 mg 1 tablet by mouth every 8 hours for pain in five out of 37 (13%) opportunities on: 12/21/25 10:47 PM 12/22/25 7:49 AM 12/22/25 2:55 PM 12/22/25 10:05 PM 12/27/25 1:58 PM	**3225.8.8.2** 1. The medication prescriptions for R3 have been acquired and administered per physician orders once identified as being unavailable. 2. All hospice residents in the memory care unit have the potential to be affected by the practice. An audit of all hospice memory care residents' medication exemption records and physician orders was conducted and has been reviewed and reconciled. 3. Facility Licensed Practical Nurses (LPNs) and Medication Technicians (MTs) will be reeducated by the Director of Resident Care on required protocols when medications are unavailable and cannot be administered per physician order. Medication Technician reeducation emphasized immediate identification of unavailable medications, prompt notification to licensed nursing staff, and proper documentation of missed or delayed doses per policy on MAR, with the understanding that medications may not be omitted or delayed without nurse notification. Licensed nursing staff reeducation emphasized immediate follow-up, including contacting the pharmacy, notifying the prescribing physician as required, obtaining and implementing any new or revised orders, and continuing follow-up until the medication is received and administered per order. Education further reinforced that all follow-up actions, communications, and outcomes must be documented in the resident's medical record, and that licensed nursing staff retain responsibility for clinical oversight and documentation until the medication is administered as ordered. 4. The Director of Resident Care will review, and audit hospice memory care residents'	2/09/2026

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	Further review of R3's MAR revealed the following medications with missing doses: Lorazepam 0.5 mg 1 tablet by mouth three times daily for anxiety or agitation in one out of 37 (3%) opportunity on 12/22/25 1:00 PM Acetamin tablet 500 mg tablet give 1 tablet by mouth three times daily for pain in three out of 37 (8%) opportunities on: 12/22/25 1:00 PM 12/22/25 4:57 PM 12/31/25 8:39 AM Gabapentin 100 mg capsule take two (2) capsules (200 mg) by mouth three times daily for nerve pain in three out of 37 (8%) opportunities on: 12/22/25 1:00 PM 12/30/25 6:13 PM 12/31/25 8:38 PM Senna tab 8.6 mg tablet take 1 tablet by mouth once daily for constipation in two out of 12 (17%) opportunities on: 12/22/25 7:00 PM 12/27/25 8:27 PM Stool softener 100 mg tablet take 1 tablet by mouth at bedtime for constipation in eight out of 12 (67%) opportunities on: 12/22/25 8:03 PM 12/24/25 7:57 PM 12/25/25 8:23 PM	medication administration exemption records as compared to physician orders. Audits will be daily for 30 days until 100% compliance is achieved and then weekly for 1 month until 100% compliance is achieved. Results of these audits will be provided to the Executive Director for review. Based on audit findings, the Executive Director will be responsible for directing additional corrective actions, which will at minimum include adjusting the frequency of the audits according to outcomes.	

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	12/26/25 5:06 PM 12/27/25 8:27 PM 12/28/25 9:10 PM 12/29/25 9:19 PM 12/30/25 9:43 P 12/31/25 – A review of R3's nurse progress notes lacked evidence that the facility physician nor the hospice physician was notified of the above listed unavailable medications. 12/31/25 12:30 PM – During an interview, E3 (DMC) stated that R3 had multiple missing doses due to unavailability of medications. E3 stated that the nurses called hospice to notify H1. 12/31/25 2:01 PM – In an interview, H1 (Hospice Physician) stated, "Those medications listed as unavailable had their prescriptions refilled electronically for at least 2 months' supply and we sent it to [facility pharmacy ... but sometimes the pharmacy just sends a certain number of tablets or pills ... it's on the pharmacy ... I don't know how their cycle of refills works but from our end we refill them." When asked if he received phone calls from the facility notifying him that medication supply is running low, or if R3 has not been getting her supply of medications from the pharmacy... H1 confirmed and further stated that he did not receive referrals to any hospice hotline telecare calls coming from [facility] regarding R3's unavailable medications, "... and then I was the on call physician last night (12/30/25), and if the facility called to notify me that [R3] had no gabapentin, I could have		

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	gotten it from [an outside pharmacy] to ensure the medication gets delivered and [R3] would not have missed those doses on 12/30/25 evening and 12/31/25 morning." 12/31/25 4:00 PM – Findings were discussed with E1 (ED) and E2 (DRC). 1/2/26 1:30 PM – Findings were reviewed with E1 (ED), E2 (DRC) and E3 (DMC) during the Exit Conference.		

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