



**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

Page 1 of 10

NAME OF FACILITY: Harmony at Kent

DATE SURVEY COMPLETED: August 12, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225.0	An unannounced complaint visit was conducted at this facility from August 10 through August 12, 2026. The deficiencies contained in this report are based on interviews, record review, and review of other facility documentation. The facility census on the first day of the survey was sixty-five (65). The survey sample totaled eight (8) residents. Abbreviations/definitions used in this report are as follows: DON – Director of Nursing LPN – Licensed Practical Nurse; NHA – Nursing Home Administrator; RN – Registered Nurse; UAI – Universal Assessment Instrument; Duoderm – Skin care treatment.		
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 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.	3552.11.0 3225.11.2 S/S-D 1. UAI has been updated for accuracy. All wound care provider notes will be placed in the resident's clinical record for review. 2. This failed practice has the potential to affect all residents as identified by the resident census. 3. Effective Immediately, prior to admission, the Healthcare Director or designee will verify the required UAI assessment has been completed by an RN within the required timeframe. The admission process will include a review of the resident's medical history, current diagnosis, medications, treatments, skin integrity, wound, mobility, ADL needs, and other identified care needs.	Completed: 9/25/2026
3225.11.0	Resident Assessment		

Provider's Signature

Title Executive Director

Date 9/8/2026



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3225.11.2 S/S-D	A resident seeking entrance shall have an Initial UAI-based resident assessment completed by a registered nurse (RN) acting on behalf of the assisted living facility no more than 30 days prior to admission. In all cases, the assessment shall be completed prior to admission. Such assessment shall be reviewed by an RN within 30 days after admission and, if appropriate, revised. If the resident requires specialized medical, therapeutic, nursing services, or assistive technology, that component of the assessment must be performed by personnel qualified in that specialty area. Based on record review and interviews it was determined that for one (R4) out of eight residents reviewed the facility failed to ensure a complete and accurate UAI was conducted prior to admission. Findings include: 4/16/26 - UAI assessment pre-admission documented, "Pressure (stage 1 or 2?), Right buttock" and "Pressure wound noted by family followed by (dermatology group name). Current treatment cleanse with saline and apply Mupirocin. Following with derm this week. Staging requested. Wound described by family may have started as a deep tissue injury". This assessment was completed by the former DON (E3). The above assessment lacked a description and measurements of the wound. 4/29/26 - The Service Plan documented under "Nursing Collaboration with external provider services" the goal "Resident will maintain and/or maximize current level of functioning with nursing collaboration with external provider services Anytime during shift as	The Healthcare Director and/or designee will review the resident's UAI and service plan agreement following admission and ensure identified needs are appropriately reflected in the resident's service plan. The Executive Director will in-service the nurses responsible for admissions, assessments, and service plan agreements regarding the requirement to complete and accurately reflect resident needs in the UAI and service plan agreement. 4.The Healthcare Director or designee will conduct weekly audits of newly admitted residents' records weekly, starting the week of September 8, 2026, and will audit records weekly until all records are reviewed to 100% completion. Audit findings will be reported to the facilities Quality Assurance committee. Any noncompliance will be corrected immediately.	

Provider's Signature

[Signature]

Title

Executive Director

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	needed". The "Action" was "Outside Services: Wound Care" and "Wound Care: Following with dermatology". This Plan lacked specifics about who was caring for the wound, what that method and frequency of communication with the outside provider was to be, any specifics about the wound care including who the outside provider was and what type of wound they were caring for. 5/16/26 - Resident was admitted to the facility. 5/16/26 9:14 PM - A nursing note in the EMR documented, "...resident right buttock has opening and it being treated with Duoderm Q (every) 5 days per daughter's account". 5/20/26 - Review of the EMR documented, "Wound referral to (name of home care provider)". 5/21/26 - Review of the 30-day post admission UAI documented under "Skin Care / Treatments" that the resident had skin ulcers but did not indicate if they were pressure or stasis (vascular). Additionally, the areas "red-dened areas/frequent assessments" and "decubitus care required (stated 1,2)" were checked. The assessment lacked location, description, measurements, wound type, stage, and treatment. The assessment was signed by E2 (current DON). 6/10/26 - An assessment in the EMR documented, "PU (pressure ulcer) to right lower buttocks".		

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	8/11/26 – An interview with E2 about the facility's assessment of R4's pressure ulcer revealed that the facility contracts with an outside provider. The surveyor shared that no assessment by the facility described the wound prior to admission and there was no ongoing documentation about the wound in the clinical record. E2 stated she would have to obtain documentation from the outside provider. 8/12/26 – An interview with F1 (R4's daughter) with resident's spouse present revealed that when E3 came to the home to do the pre-admission assessment that no physical assessment was done including looking at the wound on the buttocks. The facility failed to conduct a thorough assessment of R4's skin and wound prior to admission, upon admission, and during the 30-day post-admission assessment. Additionally, the facility failed to collaborate with the outside wound care provider regarding the wound. 8/12/26 3:51 PM – Findings reviewed with E1 (NHA) and E2 (DON) during the exit conference.		
3225.14.0	Resident Rights		
3225.14.1	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.	3225.14.0, 3225.14.1, S/S- D	Completed: 9/25/2026
S/S- D	1121. Resident's right (9) Each resident shall receive respect and privacy in the resident's own medical care	1. The Executive Director and DON reviewed the incident involving R4, including the grievance, visitor access, disclosures made to the outside practitioner, consent documentation, the resident's decision-making status, and the availability of POA or authorized-representative documents. R4's record was updated to identify the legally authorized representative	

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	program. Case discussions, consultation, examination, and treatment shall be confidential, and shall be conducted discreetly. a. At the resident's discretion, persons not directly involved in the resident's care may not be permitted to be present during such discussions, consultations, examinations, or treatment, except with the consent of the resident. Based on record review and interviews it was determined that for one (R4) out of residents eight reviewed the facility failed to protect resident privacy. Findings include: 5/16/26 – Resident was admitted to the facility with diagnoses including Alzheimer's dementia. 6/16/26 – Review of a grievance emailed to E2 (DON) by F1 (family member/POA) documented, "I am writing to request an immediate investigation into a highly concerning incident involving my father [R4] and assisted living resident at Harmony at Kent. On Friday 6/12, while my daughter was visiting my father and I was out with my mother, a woman by the name [E4] represented herself as someone there to assess my father and provide wound care...Neither my father nor our family authorized services from [E4, NP] or any company she may represent. We did not request an assessment, wound care services, or any other medical treatment from her..." Review of admission paperwork documented that although R4 and his spouse both signed the documents, F1 co-signed for R4 as POA. No POA document was available in the record.	and the scope of that person's authority based on verified documentation. A copy of the applicable POA document was obtained and placed in an accessible section of the clinical record. 2. This failed practice has the potential to affect all residents as identified by the resident census. 3. The Executive Director re-educated nursing staff and caregiving staff regarding HIPAA regulations and not to disclose any residents' protected health information, or permit assessment or treatment by, an unauthorized provider. 4. The Executive Director or designee will audit new admissions weekly starting September 8, 2026, until 100% compliance has been obtained for the representative, POA, consent, and provider information. Grievance logs will be reviewed by the Executive Director or designee weekly for four weeks, then monthly for two months to ensure compliance. Audit findings will be reported to the facilities Quality Assurance committee. Any noncompliance will be corrected immediately.	

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	8/12/26 11:35 AM – An interview with F1 in the presence of her parents revealed that she has POA of her father and had provided a copy of the document to the former marketing/business office manager during the admission process. F1 further stated that is why she signed all the admission paperwork as POA. Her father did "ceremonially" also sign upon admission. F1 also shared that she did not believe it was her father's actual signature on the Consent to Treat form from the wound care nurse (E4). 8/14/26 – A statement from E4 provided by her legal representative documented, "...On June 12, 2026 [E4] went to Harmony at Kent for a scheduled visit with a patient under her care. While there, a nurse [E5] who knows [E4] as a wound care specialist, told [E4] about another patient with a wound on his buttocks and asked if she would see him. [E4] agreed and she was accompanied to the dining area where she was introduced to [R4]. [R4] was having lunch with his wife. [E4] introduced herself and said she understood he had a wound, [R4] explained it was on his buttock and that it hurt while sitting. [E4] asked if he would like her to take a look and [R4] said yes. [E4] suggested that [R4] continue to enjoy lunch with his wife and assured him that she would come by to see him in a little while...". The statement later reads, "...[E4] was satisfied that he was fully competent and possessed decision making capacity. She then asked if he wanted her to take a look and he said yes. [E4] then presented him with a Consent to Treat form and discussed it with him. He executed the form...[E4] did indeed take a look..." Despite conflicting statements and interviews it was clear that R4's privacy was		

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S/S - F	breached when discussions about E4's wound were conducted without consent of the resident and their responsible party. Additionally, E4 was able to obtain verbal and written consent from a resident with Alzheimer's dementia and assess R4's wound without review of the records and determination if there was a Power of Attorney / responsible party decision maker. 8/12/26 3:51 PM - Findings reviewed with E1 (NHA) and E2 (DON) during the exit conference. 1107. Inspections and monitoring. (c) Any duly authorized employee or agent of the Department may enter and inspect any facility licensed under this chapter without notice at any time. All licensees are required to provide immediate access to Department personnel to conduct inspections. Such inspections may include any of the following: (3) Reviewing and photocopying any records and documents maintained by the licensee. Based on record review and interviews it was determined that the facility failed to provide timely and complete access to the residents' clinical records. Findings include: 8/10/26 around 10:45 AM - A DHCQ surveyor arrived at the facility for a complaint visit. 8/10/26 around 1:00 PM - A second surveyor arrived at the facility for the complaint visit. The facility had yet to provide a list of residents in the facility and access to the electronic medical records where most of the clinical information was stored.	S/S-F 1107. 1. Active surveyor access accounts were created internally and provided to the surveyor, after determining the emails were sent to a bogus address. The facility identified where provider and consultant notes are maintained and established a process to provide those records immediately in electronic or printed form when they are not directly visible in the primary EMR. Regional Director of Operations in-serviced the Executive Director regarding the request for electronic access and the timeliness of gathering information. 2. This failed practice has the potential to affect all residents as identified by the resident census. 3. Upon arrival of state surveyors or receipt of a records request and electronic records request, the Executive Director or designee will review the request and provide requested records and/or electronic records within 2 hours of arrival to the facility.	Completed: 9/25/2026

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	8/10/26 1:02 PM – An email with an Entrance Conference worksheet attached was sent to E1 (NHA). The Entrance Conference worksheet included "Information to Provide WITHIN ONE (1) HOUR of Entrance #8. Computer access for each surveyor to electronic documentation, if applicable". 8/10/26 - 1:03 PM – A discussion with E1 (NHA) about having him print off two documents one survey sign and the entrance sheet that included the request for EHR. 8/10/26 2:26 PM – An email was sent to E2 with the entrance conference worksheet. In addition, a discussion requesting access as soon as possible was held. The following continued on 8/10/26: 2:45 PM – E2 had provided surveyor with instructions on how to access the EMR but the instructions did not include login or password information. E2 shared it would be our work email. This was attempted despite never providing the facility with our email. This did not work. 3:10 PM – The surveyor communicated with E2 that we still could not access the EMR. E2 stated that she would contact the EMR company and get us a log in. 3:18 PM – No surveyor contact yet. 3:28 PM – No surveyor contact yet. 3:35 PM – No surveyor contact yet. 4 PM – Surveyor provided a list of sign-in names however the instructions required a	4. The Executive or designee will test the internal access request system monthly to ensure electronic records are accessible immediately to ensure compliance, starting September 8, 2026. Any discrepancies noted will be addressed immediately.	

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	password reset with an email going to an unknown location to verify. 4:08 PM – The surveyor went to E1 and E2 to let them know the log in was not working. 4:12 PM – E2 requested I try to reset password again and E2 requested my email address. 4:30 PM – The first surveyor gained access when it was determined that the password reset email goes to the E1. Then E1 must create a new password to provide to the surveyor. Then a PIN # had to be provided by the facility and reset by the surveyor. Passwords were provided for both surveyors. 8/11/26 around 8:30 AM – E1 had to reset password to assist surveyor to get into the medical records. The surveyor then had to provide their personal cell phone to get a verification text to access the EMR. 8/11/26 – Upon review of the EMR it was found that provider and consultant notes were not available. 8/12/26 3:51 PM – Findings reviewed with E1 (NHA) and E2 (DON) during the exit conference.		

Provider's Signature

Philip Miller

Title

Executive Director

Date

9/8/2026