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
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STATE SURVEY REPORT

NAME OF FACILITY: Harbor Chase of Wilmington

DATE SURVEY COMPLETED: November 7, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Complaint survey was conducted at this facility from November 3, 2025, through November 7, 2025. The deficiencies contained in this report are based on interview, observation, and record review. The facility census on the entrance day of the survey was ninety-one (91). The survey sample was composed of six (6) residents. Abbreviations/definitions used in this state report are as follows: ADL – (Activities of Daily Living) – tasks needed for daily living (dressing, hygiene, eating, toileting, bathing); AL – Assisted Living; CP – (Care Partner) – unlicensed associates who provides assistance with ADLs. Cove – facility name for the memory care unit; Del. C. – Delaware Code; Delusions – a false belief; Dementia – brain disorder with memory loss, poor judgement, personality changes and disorientation; DMC – Director of Memory Care; DON – Director of Nursing; DRC – Director of Resident care (also known as DON); ED – Executive Director;		

Provider's Signature Steven Yohay LNHA Title Executive Director Date 12/30/25

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	Frontotemporal dementia - a type of dementia that affects the areas of the brain associated with personality, behavior and language; LPN – Licensed Practical Nurse; MA – (Medication Associate) – also known as Med Tech MC – Memory Care; MCS – Memory Care Specialist; NP – Nurse Practitioner; POA – (Power of Attorney) – authority to act on behalf of another person; RN – Registered Nurse; Service Agreement – a written document developed with each resident that describes what services will be provided, who will provide the services, when the services will be provided, how the services will be provided, and if applicable, the expected outcome; Significant Change – a major deterioration or improvement in a resident's health status or ability to perform activities of daily living (toileting, bathing, eating); UAI (Uniform Assessment Instrument) - a document setting forth standardized criteria developed by the Division to assess each resident's functional, cognitive, physical, medical, and psychosocial needs and status by a Registered Nurse. The assisted living facility shall be required to use the UAI to evaluate each resident on both an initial and an ongoing basis in accordance with these regulations.		

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3225.0 **3225.5.0** **3225.5.10** **S/S – D**	**Assisted Living Facilities** **General Requirements** **The provisions of 5.9 above do not apply to residents under the care of a Hospice program licensed by the Department as long as the Hospice program provides written assurance that, in conjunction with care provided by the assisted living, all of the resident's needs will be met without placing other residents at risk.** **This requirement is not met as evidenced by:** Based on record review and interview, it was determined that for one (R1) out of one sampled resident for hospice, the facility failed to ensure that R1's need was met when she was not seen and examined by a licensed hospice clinician after R1 was found to have red blood discharge on her incontinence pad after a sexual encounter with R5 on 10/21/25. Findings include: 10/22/25 3:15 PM – An email correspondence from E1 (ED) addressed to E2 (DRC) documented that on 10/21/25 at approximately 6:28 PM, E7 (MA) observed R5 and R1 having a sexual interaction ... [E8, CP] reported that [E8] provided evening care to [R1] afterward, noting that [R1] was calm, cooperative, and at baseline, no signs of distress ...". 11/3/25 1:50 PM – In an interview, P1 (facility NP) revealed that she had not seen or examined R1 after R1's encounter with R5. 11/3/25 2:08 PM – During an interview E3 (DMC) stated, "The staff told me of the blood they saw on [R1's] incontinence pad but [R1]	**3225.5.10** 1. The hospice medical provider saw and examined R1 and conducted a medical evaluation. 2. All hospice residents residing in the memory care unit have the potential to be affected by the practice. An audit of all memory care current residents on hospice care was conducted and updated with current information as needed. 3. All facility licensed personnel and medication technicians were reeducated by the Director of Resident Care and Memory Care Director on reasons to contact hospice services for additional support within the community. Reasons to include, but not limited to, are the following: pain uncontrolled with medication; agitation or anxiety uncontrolled by medication; seizures; fainting; difficulty breathing; bleeding that cannot be controlled; no urine for greater than 12 hours; skin breakdown; nausea and vomiting uncontrolled by medication; constipation or diarrhea; several resident falls; resident stops breathing; increased spiritual and/or emotional distress; equipment malfunction; any medication, treatment or therapy starts or stops; medication refills; supply needs; laboratory tests or x-rays are ordered; changes in sexual intimacy, sexual expression, or interpersonal relationships that may reflect emotional distress, altered cognition, or a change in the resident's condition. 4. The Business Office manager will audit all new hire educational training transcripts to ensure hospice education is completed prior	12/19/2025

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	has a history of hemorrhoids and fecal impaction. So, the blood must come from that." When asked if R1 was seen by a physician after the interaction, E3 stated, "Hospice saw her." 11/3/25 3:30 PM – In an interview, E8 (CP) stated that she was the staff assigned to provide care to R1 that evening shift on 10/21/25. E8 stated that she was in the memory care dining room wiping and cleaning the tables and she observed R1 and R5 sitting in the dining room, talking. After 10-15 minutes, she was called by another Care Partner [E13] to let her know that R1 was in her room in bed with R5 on top of her. E8 stated, "I immediately went to [R1's] room with [E13] and provided personal care. We were not sure if there was penetration or not, but I saw bright red blood on [R1's] incontinent pad. [R1's] private area was slight pinkish-red and that [R1] stated that her [R1] left hip was hurting." 11/4/25 11:42 AM – During a telephone interview, P3 (Hospice Nurse) revealed that she was not notified of the blood found in R1's incontinence pad on 10/21/25. P3 stated that she learned about R1 and R5's interaction from the staff talking when she came to visit R1 on 10/27/25 for a follow up post fall visit. P3 also stated that, "[R1's] family also told me about it but not from the nursing staff. No. I did not receive a call regarding rectal bleeding from R1's hemorrhoid. Nursing staff should have contacted me or our hospice hotline number. But if it was vaginal bleeding from the penetration, the facility physician should have checked on [R1] as it's not part of R1's hospice diagnosis."	to actual on the job training as a part of new hire orientation. The Business Office manager will also audit that all current associates have completed hospice education as part of continuing their employment. Audits will be weekly for four weeks until 100% compliance is achieved and then monthly for 2 months 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.	

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	The facility failed to ensure that R1's need was met when R1 was not seen and examined by a medical provider after she was found to have red blood discharge on her incontinence pad after a sexual encounter with R5 on 10/21/25. 11/6/25 7:00 PM – Findings were discussed with E1 (ED) and E2 (DRC). 11/7/25 1:00 PM – Findings were reviewed with E1 and E2 during the Exit Conference.		
3225. **3225.8.0** **3225.8.8.2** **S/S – E**	**Resident's Right** **(13) Each resident shall receive care that meets professional standards.** **Medication Management** **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 (R1) out of three residents sampled for medication administration, the facility failed to ensure that R1's medication was administered per the physician's orders. Findings include: 2/28/25 – R1 was admitted to the facility with diagnoses including but not limited to dementia and anxiety. R1's clinical record documented that she was alert and oriented only to herself. 9/26/25 – R1's clinical record documented, "Lorazepam 1 mg, give 1 tablet by mouth every 4 hours as needed for anxiety."	**3225.8.8.2** 1. The medication prescription for R1 has been corrected and administered per physician order once identified as being incorrectly administered. 2. All residents in the memory care unit have the potential to be affected by the practice. An audit of all memory care residents' physician orders was conducted and has been reviewed and reconciled. 3. Facility Licensed Practical Nurses and Medication Technicians have been in serviced on the core five rights of medication administration; right patient, right drug, right dose, right route, right time. Reeducation to MT included reasons to communicate with nurses when needing clarification of orders. 4. The Director of Memory Care will review and audit memory care residents' medication	12/19/2025

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	10/23/25 – R1's clinical record documented, "Lorazepam 0.5 mg, take 1 tablet by mouth twice daily for anxiety." 10/23/25 9:00 PM – R1's clinical record lacked evidence that the medication was given. 10/24/25 9:00 AM – R1 received 1 mg of lorazepam. The PM dose was not given. 10/25/25 9:00 AM – R1 received 1 mg of lorazepam. The PM dose was not given. 10/26/25 9:00 AM – R1 received 1 mg of lorazepam. The PM dose was not given. 10/28/25 9:00 AM – R1 received 1 mg of lorazepam. The PM dose was not given. The facility failed to ensure that lorazepam order was entered correctly into the medication administration record. This failure caused R1 to miss 5 doses of medication and received 4 incorrect doses. 10/29/25 10:32 AM – R1's clinical record documented, "Lorazepam 0.5 mg, take 1/2 tablet [1/2 of 1 mg tablet] by mouth twice a day for anxiety. 10/29/25 5:35 PM – R1 received 1 mg of lorazepam. 10/30/25 9:00 AM – R1 received 1 mg of lorazepam. 10/30/25 5:34 PM – R1 received 1 mg of lorazepam. 10/31/25 9:00 AM – R1 received 0.5 mg [1/2/ of a 1 mg tablet] of lorazepam.	administration records as compared to physician orders. Audits will be weekly for four weeks until 100% compliance is achieved and then monthly for 2 months 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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	10/31/25 8:00 PM – R1 received 0.5 mg [1/2 of a 1 mg tablet] of lorazepam. 11/1/25 9:00 AM – R1 received 0.5 mg [1/2/ of a 1 mg tablet] of lorazepam. 11/1/25 8:00 PM – R1 received 1 mg of lorazepam. 11/2/25 9:00 AM – R1 received 1 mg of lorazepam. 11/2/25 8:00 PM – R1 received 0.5 mg [1/2 of a 1 mg tablet] of lorazepam. 11/3/25 8:30 AM – R1 received 0.5 mg [1/2 of a 1 mg tablet] of lorazepam. 11/3/25 6:00 PM – R1 received 0.5 mg [1/2 of a1 mg tablet] of lorazepam. The facility failed to ensure that R1 received the incorrect medication doses for 11 out of 11 opportunities. 11/4/25 2:30 PM – During an interview, E3 (LPN) stated, "The order was entered incorrectly, and we had the 1 mg of lorazepam on hand because there was an order to give [1 mg of lorazepam] as needed. The staff did not realize that they were giving her the wrong dose." The facility failed to ensure that R1's medication was administered according to the physician's order for a total of 20 doses. 11/4/25 3:00 PM – Finding was confirmed with E2 (DRC.)		
3225.11.0 **3225.11.5**	**Resident Assessment** **The UAI developed by the Department, shall be used to update the resident assessment.**		

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S/S – D	**At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.** **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for two (R1 and R5) out of six sampled residents, the facility failed to ensure that the residents' UAI assessments were updated when there were significant changes for R1 and R5. Findings include: 1. Review of R1's clinical record revealed: 4/1/24 – R1's initial UAI assessment documented that R1 was oriented to person and place, had confusion at night, and occasional early morning agitation. R1 was not under hospice services. 4/1/25 – R1 was initially admitted to the assisted living facility with diagnoses including dementia. 4/29/25 – R1's 30-day UAI assessment revealed no change. 5/5/25 7:35 PM – A nurse progress note documented that FM2 (R1's daughter) came to speak regarding R1 having a mental status change, crying all the time and calling R1's daughters in the early morning hours. 5/27/25 1:39 PM – A nurse progress notes documented, "... [R1] continues with crying even when her needs are met. [R1] noted with increased accusation of staff trying to poison her food, coffee and others...".	**3225.11.5** 1. The UAI's for both R1 and R5 have been reviewed and updated to include current resident assessment data information. 2. All residents in the memory care unit have the potential to be affected by the practice. An audit of all current memory care resident UAI's was conducted and has been reviewed and updated with current assessment information as needed. 3. Facility Registered Nurses have been in serviced on the timing and correlation of the UAI and Service Agreement to accurately reflect a resident's physical, medical, and psychosocial services that a resident requires as outlined 3225.11. The RN Assessment Coordinator will attend the weekly "At Risk" meeting where upcoming assessments and changes in resident's needs are discussed and the information obtained will be reflected on the current UAI. 4. The Director of Resident Care will review all newly completed UAI's for memory care residents to ensure the residents' physical, medical, and psychosocial services are reflected in the UAI. Audits will be weekly for four weeks until 100% compliance is achieved and then monthly for 2 months 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.	12/3/2025

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	7/16/25 – R1 had a significant change UAI assessment which documented that R1 was oriented to person only with occasional agitation in the morning. R1 was not under hospice services. 9/8/25 – An encounter note by P2 (NP) documented that R1 had intermittent explosive disorder and continued to have periods of agitation and confusion. 9/25/25 – R1 was admitted under hospice services. 9/25/25 – A hospice initial Certification of Terminal Illness Form by P4 (Hospice MD) documented that R1 was recently moved into a memory care unit due to declining functional status and is now only alert and oriented to self. 11/3/25 12:10 PM – An interview with E5 (Memory Care Specialist/MCS) revealed that R1 was transferred to the memory care unit sometime in July 2025 and that R1 had behaviors of acting out and crying when not in the company of men. E5 stated that R1 "...Perks up when a gentleman is around ... [R1] has also been falling a lot with behavior issues and is now on hospice." When asked if E5 completed a significant change in condition UAI for R1 when she was admitted under hospice services, E5 stated, "It's [E2, DRC] who does it. She's the RN." 11/6/25 1:20 PM – During an interview, E2 confirmed that a significant change in condition UAI was not completed when R1 was admitted under hospice services on 9/25/25. 11/6/25 7:00 PM – Findings were discussed with E1 (ED) and E2 (DRC).		

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	2. Review of R5's clinical record revealed: 12/30/24 - R5's annual UAI assessment documented that R5 was alert, oriented to person, place and time with short term memory problem, and was independent with mobility and transferring. R5 was noted to be occasionally socially inappropriate. Review of R5's nurse progress notes from January through September 2025 revealed the following: 1/25/25 4:12 PM – "This nurse was talking to a care partner today ... the other day ... [R5] came up from behind and started to play with (care partner's) ponytail and asked her 'How did it feel' ... This nurse again was reading emails and the concierge sent this to the nursing staff and administration: Tonight at 7:55 PM [R5] walked into AL1's [female resident] apartment. [AL1] was screaming, which got E13 (Care Partner) and my attention. [AL1] thought her door was locked, by (sic) [R5] opened the door and went in. [AL1] is very upset..." 2/7/25 2:33 PM – R5 was moved to the memory care unit. 2/21/25 11:18 AM – R5 tried to exit the floor (memory care unit) and was found in the parking lot by the receptionist. 2/22/25 12:17 PM – R5 was inappropriate to staff (unidentified) asking her to come to bed with him.		

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	4/3/25 10:21 PM – R5 smacked a Med Tech (unidentified MA) on her buttocks. 4/4/25 11:36 AM – "... an incident that occurred yesterday... Care Partner (unidentified) saw [R5] reach out to the Med Tech (unidentified MA) and smacked her on her buttocks x2." 6/1/25 – R5 told a female resident (unidentified) at breakfast table that she can take her top off if she would like. 10/22/25 – An encounter notes by P1 (facility NP) documented that she was notified by the facility that R5 had sexual relations with R1 "last night" (10/21/25) and that "Staff reports this was consensual." There was a lack of evidence that R5's UAI was updated to reflect R5's significant change in condition when he was noted to have increased inappropriate sexual behaviors, wandering and his transfer to the memory care unit on 2/7/25. 11/6/25 7:00 PM – Findings were discussed with E1 (ED) and E2 (DRC). 11/7/25 1:00 PM – Findings were reviewed with E1 and E2 during the exit conference.		
3225.13.0 **3225.13.6** **S/S – D**	**Service Agreement** **The service agreement shall be reviewed when the needs of the resident have changed and, minimally, in conjunction with each UAI. Within 10 days of such assess-**		

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	ment, the resident and the assisted living facility shall execute a revised service agreement, if indicated. **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for two (R1and R5) out of six sampled residents, the facility failed to ensure that the residents' service agreements were updated to address R1 and R5's identified needs. Findings include: 1. Review of R1's clinical record revealed: 4/1/25 – R1 was admitted into the facility. 4/1/25 – R1's initial Resident Personal Service Plan and Assisted Living Evaluation form (Service Agreement) revealed that R1 was not receiving hospice services. 7/15/25 – R1 was moved to the memory care unit. 7/16/25 – R1's significant change Resident Personal Service Plan and Assisted Living Evaluation revealed that R1 was not receiving hospice services. 9/2/25 – A hospice initial certification documented that R1 was certified for hospice services due to diagnosis of atherosclerosis and R1's declining functional status. 9/25/25 - A hospice admission order documented that R1 was admitted under hospice services.	**3225.13.6** 1. The service agreement for both R1 and R5 has been reviewed and updated to include current resident assessment data information. 2. All residents in the memory care unit have the potential to be affected by the practice. An audit of all memory care current residents service agreements was conducted and have been reviewed and updated with current assessment information as needed. 3. Facility Registered Nurses have been in serviced on the timing and correlation of the UAI and Service Agreement to accurately reflect a resident's physical, medical, and psychosocial services that a resident requires as outlined in 3225.13. The RN Assessment Coordinator will attend the weekly "At Risk" meeting where upcoming assessments and changes in resident's needs are discussed and the information obtained will be reflected on the current service plan. 4. The Director of Memory Care will review all newly completed service agreements for memory care residents to ensure the residents' physical, medical, and psychosocial services are reflected in the service agreement. Audits will be weekly for four weeks until 100% compliance is achieved and then monthly for 2 months 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.	12/3/2025

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	The facility failed to update R1's service agreement when R1 was admitted under hospice services on 9/25/25. 11/6/25 7:00 PM – Findings were discussed with E1 (ED) and E2 (DRC). 2. Review of R5's clinical record revealed: 1/7/25 – R5's annual Resident Personal Service Plan and Assisted Living Evaluation form (Service Agreement) revealed that R5 ambulates independently and did not require verbal reminders and escort to activities. R5 did not exhibit disruptive, exit seeking, wandering and agitated behaviors. A review of R5's nurse progress notes from January 2025 through June 2025 revealed the following: - R5 walked into AL1's (Assisted Living resident) room. - R5 was transferred to the memory care unit. - R5 tried to exit the floor and was found in the parking lot. - R5 told a staff to come to bed with him. - R5 told a female resident at breakfast table that she can take her top off if she would like. There was a lack of evidence that R5's service agreement was updated to reflect R5's significant change in condition when he was noted to have increased inappropriate sexual behaviors, wandering and his transfer to the memory care unit on 2/7/25.		

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Subchapter III Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents 1131. Definitions For purposes of this subchapter: S/S - IJ	11/6/25 7:00 PM – Findings were discussed with E1 (ED) and E2 (DRC). 11/7/25 1:00 PM – Findings were reviewed with E1 and E2 during the Exit Conference. **Title 16 Health and Safety** **(12) "Neglect" means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect includes all of the following: ... b. Failure to report patient or resident health problems or changes in health problems or changes in health condition to an immediate supervisor or nurse ...".** **This requirement was not met as evidenced by:** Based on observation, interview and record review, it was determined that for two (R5 and R1) out of three residents reviewed for sexual abuse, the facility failed to ensure that R5 and R1, both residents in the memory care unit, were free from neglect by allowing residents that where not assessed for decision making capacity to engage in sexual relations. As a result, the lack of assessment of R5's cognition status and capacity to consent to engage in sexual relations placed other residents in the memory care unit at Immediate Jeopardy (IJ) for further inappropriate sexual behaviors, advances and abuse by R5. The lack of accurate assessment of R1's cognition status and capacity to consent to engage in sexual relations placed R1 at immediate jeopardy for further inappropriate sexual behaviors, advances and abuse by R5. The IJ was identified on 11/6/25 at 1:58 PM and	**Title 16 Health and Safety (12)** 1. Medical providers assessed both R1 and R5 and provided a consent/capacity assessment. Previous sexual consent assessment completed on 11/4/2025 has been voided. No other incidents of sexually inappropriate contact by R5 with R1 or with other residents after the 10/21/25 incident have occurred. There had been no other identified sexual relations existing among residents in the memory care unit after the 10/21/2025 incident. 2. All residents in the memory care unit have the potential to be affected by the practice. A formal resident sexual consent/capacity assessment for all residents that was implemented on 11/4/2025 has be conducted and will continue in conjunction with the Delaware UAI and documented in their service agreements. 3. Associate training was launched and enforced on sexual intimacy, expression, and aging for all licensed personnel and direct care staff. An observation plan is implemented for R5, including increased staff observation and scheduled safety checks at indicated intervals. Associates will redirect R1 and R5 away from having any direct contact.	11/7/2025

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	was abated on 11/7/25 at 12:14 PM. Findings include: A facility policy titled, "Abuse, Neglect and Exploitation Definition/ Investigation/ Reporting/ Prohibition", reviewed 10/2/17, documented, "[Facility] is committed to maintaining a safe environment for each resident, visitor and employee. Instances or allegations of abuse or exploitation should be treated seriously and must be reported to the Executive Director or the supervisor on duty for investigation and appropriate follow – up... Definitions: ... b. "Neglect" is repeated conduct of carelessness which produces or could reasonably be expected to result in serious physical or psychological injury, or a substantial risk of death..." An undated facility policy titled, "Sexual Intimacy and Expression" documented, "[Facility] is committed to honoring the dignity, privacy, and autonomy of all residents ... older adults ... retain the right to sexual expression, provided it occurs safely, respectfully, and consensually... Consent Capacity ... [Facility] follows the principle of 'sexual consent potential' – focusing on what an individual can do and understand rather than solely on limitations..." 1. Review of R5's clinical record revealed: 3/16/24 - R5 was initially admitted to the assisted living facility with diagnoses including frontotemporal dementia (a type of dementia that affects the areas of the brain associated with personality, behavior and language).	4. The Business Office manager will audit all new hire educational training transcripts to ensure sexual intimacy, expression, and aging education is complete during new hire orientation prior to actual on the job training. The Business Office manager will also audit annually that all current associates have completed the sexual intimacy, expression, and aging education as part of continuing their employment. The Director of Memory Care will audit the documentation of the scheduled safety checks at indicated intervals for R5. The Resident Care Director will audit the memory care residents UAI's to ensure that the formal resident sexual consent/capacity assessment is conducted in conjunction with the Delaware UAI and documented in their service agreements. Audits will be weekly for four weeks until 100% compliance is achieved and then monthly for 2 months 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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	An undated Psych note by P5 (Psych MD) documented that R5 was to have a psych consult with P6 (Psych MD) on 5/1/24 and discussed with R5 appropriate behavior with staff. P5 also documented that staff should be educated about frontotemporal dementia. 12/30/24 - R5's annual UAI assessment documented that R5 was alert, oriented to person, place and time, short term memory problem and was independent with mobility and transferring. There was no indication that R5 had a history of wandering but R5 was noted to be occasionally socially inappropriate. 1/7/25 – R5's annual service plan documented that R5 had no incidents of disruptive, exit seeking or wandering and agitated behaviors. Review of R5's nurse progress notes from January 2025 through September 2025 revealed the following: 1/25/25 4:12 PM – "This nurse was talking to a care partner (unidentified) today ... the other day ... [R5] came up from behind and started to play with (care partner's) ponytail and asked her 'How did it feel' ... This nurse again was reading emails and the concierge (unidentified) sent this to the nursing staff and administration: Tonight at 7:55 PM [R5] walked into AL1's [female resident] apartment. [AL1] was screaming, which got E13 (Care Partner) and my attention. [AL1] thought her door was locked, by (sic) [R5] opened the door and went in. [AL1] is very upset..."		

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	2/7/25 2:33 PM – R5 was moved to the memory care unit. 2/21/25 11:18 AM – R5 tried to exit the floor (memory care unit) and was found in the parking lot by the receptionist. 2/22/25 12:17 PM – R5 was inappropriately asking staff (unidentified) to come to bed with him. 4/3/25 10:21 PM – R5 smacked a Med Tech (unidentified MA) on her buttocks. 4/4/25 11:36 AM – "... an incident that occurred yesterday... Care Partner (unidentified) saw [R5] reach out to the Med Tech (unidentified MA) and smacked her on her buttocks x2." 6/1/25 – R5 told a female resident (unidentified) at breakfast table that she can take her top off if she would like. 10/22/25 – An encounter notes by P1 (facility NP) documented that she was notified by the facility that R5 had sexual relations with R1 "last night" (10/21/25) and that "Staff reports this was consensual." 2. Review of R1's clinical record revealed: 4/1/24 – R1's initial UAI assessment documented that R1 was oriented to person, place and had confusion at night. R1 was independent with mobility, bed mobility and transfer.		

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	4/1/25 – R1 was initially admitted to the assisted living facility with diagnoses including dementia. 4/2/25 – A new patient encounter notes by P7 (facility MD) documented, "... R1 is homebound due to mild cognitive impairment and mobility issues requiring an assist device on a chronic basis due to high fall risk...". 7/15/25 – R1 was admitted to the memory care unit. 7/16/25 – R1 had a significant change UAI assessment which documented that R1 was oriented to person only with occasional agitation in the morning. R1 was independent with mobility, bed mobility and required one-person physical assistance with transfer. 9/8/25 – An encounter notes by P2 (NP) documented that R1 had intermittent explosive disorder and continued to have periods of agitation and confusion. 9/25/25 – R1 was admitted under hospice services. 9/25/25 – A hospice initial Certification of Terminal Illness Form by (Hospice MD) documented that R1 was recently moved into a memory care unit due to declining functional status and is now only alert and oriented to self. 10/22/25 3:15 PM – Email correspondence from E1 (ED) addressed to E2 (DRC) documented a summary of resident interaction between R1 and R5. "Incident Overview – October 21, 2025, ... At approximately 6:28 p.m. [E7, MA] notified [E5, MCS] that upon entering [R1's] apartment and turning on the		

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	lights, [E7] observed [R5] positioned on top of [R1], with both residents moaning and without pants or undergarments. [E7] reported that [R1] was rubbing [R5's] back and that both residents appeared to be active and willing participants in the interaction ... [E8, CP] reported that [E8] provided evening care to [R1] afterward, noting that [R1] was calm, cooperative, and at baseline, no signs of distress ...". 11/3/25 10:40 AM – Joint interview with E1 (ED) and E2 (DRC) revealed that the facility has no written policy on sexual intimacy in the long-term care setting. When asked if written consents to engage in sexual relationship were obtained from R1 and R5, both E1 and E2 said, "No we did not obtain written consents from both residents because the incident on 10/21/25 was consensual." 11/3/25 12:06 PM – An interview with E4 (LEC) revealed that R1 was confused and has behaviors of crying and yelling. 11/3/25 12:08 PM – During an observation in the memory care unit, R1 was seen seated in her wheelchair crying. The Surveyor asked what's the matter, R1 did not give an answer. R1 was heard mumbling incoherent words. The Surveyor could not get answers when trying to engage in conversation with R1. 11/3/25 12:10 PM – An interview with E5 (Memory Care Specialist/MCS) revealed that R1 had behaviors of acting out and crying when not in the company of men. E5 stated, "[R1] perks up when a gentleman is around". 11/3/25 1:21 PM – An interview with E6 (LPN) revealed that R1 was confused and was		

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	not capable of consenting to a relationship with R5. E6 stated that R5 had a history of going into another female resident's room (R6), "who does not speak a lot for herself." 11/3/25 1:50 PM – An interview with P1 (facility NP) revealed that she did not think R1 was capable of giving consent to engage in sexual relations. 11/3/25 2:08 PM – During an interview, E3 (Interim DMC) revealed that the facility determined that what happened on 10/21/25 between R5 and R1 was consensual. E3 stated, "It was consensual because we always see them together, eating meals in the dining room together, and no push back from [R1] for [R5] to stop... But after I learned of the situation, we called our Director (E5, MCS), our DRC (E2) and ED (E1) because we didn't know what to do – as for the next steps - as this never happened before." 11/3/25 2:15 PM – In a follow up interview, E5 (MCS) stated, "...We don't determine the resident's capacity to consent themselves to engage in sexual relations. I saw R5 and R1 who were very friendly with each other. R5 is also very social with females. I never observed him being sexually inappropriate now that he is here in the memory care unit, but I know, and I am aware that he was sexually inappropriate with female staff while he was still in the AL (assisted living)." 11/3/25 3:06 PM – An Interview with E7 (MA) revealed that she entered R1's room and turned on the light. E7 stated that she saw R5 on top of R1 completely naked and R1 with no clothes from her waist down and moaning. R1's hands were rubbing R5's back. She stated she was shocked at what she saw and		

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	told R5 to get off R1. E7 stated that she called another staff E13, a Care Partner, to help her escort R5 out of R1's room. E7 stated that she heard both R1 and R5 moaning and she thought it was consensual and that there was no push back or resistance from R1. E7 further stated that even if R1 had dementia R1 was capable of making it made known what she wants and not want. 11/3/25 3:30 PM –During an interview, E8 (Care Partner) stated that she was the staff assigned to provide care to R1 that evening shift on 10/21/25. E8 stated that she was in the memory care dining room cleaning the tables and observed R1 and R5 sitting in the dining room, talking. After 10-15 minutes, E8 was called by another Care Partner [E13] to let her know that R1 was in her room in bed with R5 on top of her. E8 stated that she immediately went to R1's room and provided personal care. E8 further stated, "... I was not sure if there was penetration or not by [R5], but I saw bright red blood on [R1's] incontinent pad. R1's private area was slight pinkish-red and that [R1] told me that her 'left hip was hurting'...". 11/3/25 3:45 PM – E2 (DRC) presented to the surveyor a copy of the facility's undated policy on Sexual Intimacy and Expression. E2 stated that they only developed this policy "today" based on the content material the facility used to educate the staff after the 10/21/25 incident between R1 and R5. 11/4/25 12:19 PM – During an interview, FM1(R1's Daughter/POA) revealed that, "My mom has no capacity to consent herself to engage in sexual relations. She has been declining significantly with her cognition that's why she got moved from the assisted living to		

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	the memory care (MC). Also, during our tour in the MC unit, my sisters and I were told that the bedroom doors are always kept shut and locked because other residents wander and just enter other people's room. I don't understand why [R5] was able to enter mom's room if her apartment door was locked at all times. After that incident on 10/21/25, I asked the staff to post a note on her door for it to be always locked. Even after that happened, there was a time I was in the MC unit to visit mom and then I saw [R5] seated in front of my mom's room – and my mom's apartment door was left open, and she was in her room. I had to come to him, excused myself and told him I had to shut the door. My sisters and I hope something can be done for this not to happen again. I am worried of my mom, and I don't want her to get hurt." 11/4/25 3:30 PM – E2 (DRC) presented to this surveyor R5 and R1's facility sexual consent assessment completed by E2 on 11/4/25 which documented the following: R5 "New relationship noted, follow up to prior incident. [R5] is awake, alert and able to participate in conversation, can express agreement or refusal, understands who the partner is and the nature of the relationship – views partner as a companion, shows basic understanding of intimacy/affection – rubs shoulders, helps with sling, hold hands, eats meal together. [R5] appears comfortable and content. Accepts redirection to private spaces if needed – left when asked to. No indications of abuse or exploitation. No medical or medication concerns that would contraindicate sexual activity. Has capacity to consent to intimate sexual activity. Reviewed		

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	with IDT team 10/22/25. Reviewed "The Sexual Consent Potential Model Study" with [E1, ED] and [E3, Interim DMC] 10/22/25. Increased monitoring, medical review completed, medication adjustment." R1 "New relationship noted, follow up to prior incident. [R1] is awake, alert and able to participate in conversation, can express agreement or refusal, understands who the partner is and the nature of the relationship. Shows basic understanding of intimacy/affection - Seeks out same person – [R1]. [R1] refers to him [R5] as Jack or her husband. Hold hands, rubbing, etc. [R1] shows clear willingness to participate – seeks [R5] out. No signs of pressure, fear, or coercion – Seeks [R5] out. [R1] can stop or withdraw if uncomfortable – Able to voice uncomfortable. Interaction appears mutual and reciprocal. [R1] appears comfortable and content – with relationship with [R5]. Accepts redirection to private spaces if needed – Has not happened in public area. No indications of abuse or exploitation. No medical or medication concerns that would contraindicate sexual activity. Has capacity to consent to intimate sexual activity. Reviewed with IDT team 10/22/25. Reviewed "The Sexual Consent Potential Model Study" with [E1] and [E3] 10/22/25. Increased monitoring, hospice." Although the facility sexual consent assessments were completed for R5 and R1 on 11/4/25, the facility's clinical documentation of R5 and R1's cognition assessments and capacity to consent in sexual relations did not match. The lack of accurate assessment of R5's increasing inappropriate sexual behavior noted		

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	since January 2025 did not trigger for R5's person centered service agreement to be updated to reflect appropriate interventions to address R5's wandering and socially inappropriate sexual behaviors. In addition, the lack of assessment of R5's cognition status and capacity to consent to engage in sexual relations placed other residents in the memory care unit at immediate jeopardy for further inappropriate sexual behaviors, advances and abuse by R5. The lack of accurate assessment of R1's cognition status and capacity to consent to engage in sexual relations placed R1 at immediate jeopardy for further inappropriate sexual behaviors, advances and abuse by R5. 11/5/25 10:35 AM – An interview with P2 (Psych NP) revealed, "... [R5] was alert, oriented to person, place and time with some periods of confusion due to his frontotemporal dementia that exhibits hypersexuality or inappropriate sexual behavior as a side effect/outcome. [R5] is aware and capable of consenting himself to engage in sexual relations. [R5] was known to be hypersexual towards staff even while in the AL (assisted living) and also exhibited wandering and elopement behaviors that's why he was moved to the memory care unit in February 2025. Those were not new behaviors – those were his baseline. R5's behavior medication Paxil was also adjusted from 20 mg to 30 mg. R5 was doing well with the dosage for a while until it was bumped up again to 40 mg after the 10/21/25 incident involving R1." 11/5/25 10:36 AM – Follow up interview with P2 (Psych NP) revealed that she had R1 on		

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	her patient case load until 9/9/25 and at that time, R1 was not capable of consenting herself to engage in sexual relations. She stated, "[R1] may physically and verbally pursue [R5] but [R1] did not have the comprehension to understand the repercussion and the outcome of the sexual relations that [R1] was getting into." 11/6/25 1:58 PM – An immediate jeopardy (IJ) was called and reviewed with the facility leadership including E1 (ED) and E2 (DRC). During this conference, both E1 and E2 confirmed that there had been no other incidents of sexually inappropriate contact by R5 with R1 or with other residents after the 10/21/25 incident. E1 and E2 also confirmed that there had been no other identified sexual relations existing among residents in the memory care unit after the 10/21/25 incident. 11/6/25 6:46 PM – E1 presented to surveyor an acceptable documentation of corrective action plan that was fully abated on 11/7/25. The facility's corrective actions at that time of the incident included: - A formal resident sexual consent/capacity assessment for all residents that was implemented on 11/4/25 that will be conducted in conjunction with the Delaware UAI and documented in their service agreements. - Facility will not follow the sexual consent assessment completed on 11/4/25 that allows that R1 and R5 to continue to have a sexual relationship until both are assessed by medical providers.		

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	- Staff training was launched and enforced on sexual intimacy, expression, and aging beginning 10/30/25 and was completed on 11/7/25. -Implement an observation plan for R5, including increased staff observation and scheduled safety checks at indicated intervals (AM, Noon, Bedtime, 5:00 PM & 7:00 PM). - Associates will redirect R1 and R5 away from having any direct contact or interactions until R1 and R5 are assessed by a medical provider. This was verified by observation, review of facility documents and interview with facility staff and residents. 11/7/25 1:00 PM – Findings were reviewed with E1 (ED) and E2 (DRC) during the exit conference.		

DELAWARE HEALTH AND SOCIAL SERVICES

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

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STATE SURVEY REPORT

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