DELAWARE HEALTH AND SOCIAL SERVICES

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

DHSS - DHCQ
261 Chapman Road Suite 200
Newark, DE 19702

STATE SURVEY REPORT

NAME OF FACILITY: Kentmere Rehabilitation And Healthcare Ctr **DATE SURVEY COMPLETED:** November 22, 2024

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report.		
	A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC. on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in compliance with 42 CFR 483 subpart B.		
	Survey Dates: 11/19/24- 11/22/24.		
	Survey Census: 94		
	Sample Size: 40		
3201	Supplemental Residents: 10		
3201.1.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.2	**Scope**		
	Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.		

Provider's Signature [signature] Title Executive Director Date 12-30-2024

DELAWARE HEALTH AND SOCIAL SERVICES

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

DHSS - DHCQ
261 Chapman Road Suite 200
Newark, DE 19702

STATE SURVEY REPORT

NAME OF FACILITY: Kentmere Rehabilitation And Healthcare Ctr **DATE SURVEY COMPLETED:** November 22, 2024

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	This requirement is not met as evidenced by: Cross refer tags are F552, F554, F600, F602, F609, F641, F677, F684, F687, F688, F689, F741, F755, F803, F812, and F908.		

Provider's Signature [signature] Title Executive Director Date 12-30-2024

DELAWARE HEALTH AND SOCIAL SERVICES

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

DHSS - DHCQ
261 Chapman Road Suite 200
Newark, DE 19702

STATE SURVEY REPORT

NAME OF FACILITY: Kentmere Rehabilitation And Healthcare Ctr **DATE SURVEY COMPLETED:** November 22, 2024

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE

Provider's Signature [signature] Title Executive Director Date 12/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found to be in substantial compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC. on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in compliance with 42 CFR 483 subpart B. Survey Dates: 11/19/24- 11/22/24. Survey Census: 94 Sample Size: 40 Supplemental Residents: 10	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.	F 552		1/29/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 12/20/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 552	Continued From page 1 §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure risks vs (versus) benefits, for the use of psychotropic medications, were obtained for one of five residents (Resident (R) 3) reviewed for unnecessary medications of 40 sample residents. This failure placed residents at risk of not being informed of proposed care and treatment options. Findings include: Review of an undated facility's policy titled, "Resident Rights," revealed, " ...The Resident has the right to exercise his or her rights as provided herein. The Facility shall ensure that the Resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the Facility. The Facility will protect and promote the rights of the Resident and support the exercising of such rights ...The right to be informed of and participate in, his or her treatment, including ...The right to be fully informed of his or her total health status, including diagnosis, treatment, and prognosis ..." Review of R3's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R3 was admitted to the facility on 01/25/21 with diagnoses that included major depressive disorder.	F 552	F552 1.Resident immediately educated on the risk and benefits of her medications and consent received. 2.Audit of all residents on antidepressants completed and consents completed. 3. Residents will be reviewed quarterly at GDR meeting to ensure appropriate consents are received and updates to consents completed. 4. Social service/designee will complete weekly audit x3 weeks, of all new admissions and residents seen by psychiatric services to ensure consents are up to date until 100% compliance is achieved. then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 552	Continued From page 2 Review of a "Physician Order," 09/12/24 and located in the "Orders" tab of the EMR, revealed "Escitalopram Oxalate (an antidepressant medication) give 15 mgs [milligrams] by mouth one time a day for Depression." Review of a "Physician Order," 09/12/24 and located in the "Orders" tab of the EMR revealed, "Trazadone (an antidepressant medication) give 50 mgs by mouth at bedtime related to Insomnia." Review of the quarterly "Minimum Data Set (MDS)" assessment located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of 09/18/24 revealed that R3 had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 which indicated R3 was cognitively intact for daily decision-making and was administered antidepressant medications during the seven-day observation period. During an interview on 11/22/24 at 12:08 PM, the Director of Nursing (DON) was asked if there was documentation that R3 had been provided with the risks vs benefits for the use of the antidepressant medications, prior to being administered the medication. The DON stated, "I will look for them and get back to you." At 1:15 PM, the DON was again asked if there was documentation of the risks vs benefits for the antidepressant medications for R26. The DON stated, "Not yet, but still looking."	F 552		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that	F 554		1/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 3 this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and review of facility policy, the facility failed to ensure one cf one resident (Resident (R) 26) of 40 sample residents was allowed to self-administer cough drops per the physician order. This failure placec the resident at risk of having his right to self-administer medications violated. Findings include: Review of a facility's undated policy titled, "Resident Rights," revealed " ...The Resident has the right to exercise his or her rights as provided herein. The Facility shall ensure that the Resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the Facility. The Facility will protect and promote the rights of the Resident and support the exercising of such rights ...The right to self-administer medication if determined that such practice is clinically appropriate ..." Review of R26's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R26 was admitted to the facility on 12/21/20 with diagnoses that included chronic bronchitis and chronic obstructive pulmonary disease. Review of a "Physician Order" dated 03/28/23 and located in the "Orders" tab of the EMR, revealed "Resident may keep (name withheld) cough drops at bedside and self-administer one every four hours." Review of a quarterly "Minimum Data Set (MDS)"	F 554	F554 1.An immediate verbal self-administration assessment was completed with the resident and medication offered at bedside. 2.Audit of all residents with self-administration orders completed. For residents who have self-administration orders at bedside, a self-administration of medication assessment was completed. 3.The Staff Developer/designee will provide in-service education programs for policy, procedure, order entry and assessment. 4.Unit Managers/designee will monitor the provision of self-administration orders for (10) records per week for three (3) weeks until 100% compliance is achieved, then five (5) records monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 4	F 554		

assessment located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of 09/19/24, revealed R26 had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 which indicated R26 was cognitively intact for daily decision-making.

Review of the "Care Plan," initiated on 04/06/23 and revised on 10/01/24, located in the "Care Plan" tab of the EMR, revealed "[R26] has a physician's order for unsupervised self-administration of the following medications: (name withheld) cough drops."

During an interview on 11/19/24 at 10:30 AM, R26 stated, "Up in the cabinet at the nurses' station, I have a tin of over-the-counter cough drops, I have to ask the nurses to get them for me." R26 was asked if he had been assessed for safety by the nursing staff in order to have these cough drops in his room and administer them for himself. R26 stated, "No, they haven't."

Review of the "Assessments" tab and the "Miscellaneous" tab in the EMR did not show documentation of a self-administration assessment having been done for R26 to administer the cough drops independently.

During an interview on 11/20/24 at 2:25 PM, Unit Manager (UM) 1 was asked if R26 had a tin of cough drops in the cabinet at the nurses' station. UM1 stated, "Yes, they are here in the cabinet." UM1 was asked if R26 was able to self-administer the cough drops independently. UM1 stated, "Yes, he is able to take the cough drops independently. He comes to me and asks for them occasionally." UM1 was asked if a self-administration assessment had been done so

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 5 R26 could keep the cough drops in his room. UM1 stated, "No, there has been no assessment done."	F 554		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required tc treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and review of facility policy, the facility failed to ensure three of six residents (Resident (R) 103, R39, R105) reviewed for abuse was free from abuse. Findings include: Review of the facility's undated policy titled, "Abuse, Neglect, Mistreatment, Misappropriation, Exploitation and Reasonable Suspicions of Crime," revealed abuse was defined as the "willful infliction of injury, unreasonable confinement, intimidation, deprivation of goods or services, or punishment with resulting physical harm' pain or mental anguish, including such conduct facilitated	F 600	F600 1. An investigation was initiated once the redness was discovered and immediately the employee in question was suspended pending investigation. Resident was assessed for her injury and resident responsible party and physician were notified. 2. All residents have the potential to be affected by this alleged deficient practice. A facility audit was conducted to ensure no other residents understood how to report instances of abuse to management. No other residents have been identified as being affected by the	1/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ____ B. WING ____	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 6 or enabled through the use of technology." Physical abuse was unnecessarily inflicting pain or injury on a resident. 1. Review of R103's "Resident Profile" located under the "Resident" tab of the electronic medical record (EMR) revealed the resident was admitted on 09/20/23 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia, acute embolism and thrombosis of left femoral vein, chronic obstructive pulmonary disease unspecified, other symptoms and signs involving cognitive functions following cerebral infarction. Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/15/23 revealed a "Brief Interview for Mental Status (BIMS)" score of six out of 15 which indicated the resident had severely impaired cognition. Review of a facility reported incident, dated 11/24/23 and provided by the facility, revealed that R103 stated that when she got her nebulizer treatment the morning of 11/23/23 she informed the male nurse RN6 administering it that the mask was too tight, it was hurting her, and she felt like she couldn't breathe. R103 stated RN6 told her to shut up and be quiet and proceeded to hold the mask on her face for the duration of the treatment. Review of R103's EMR "Medication Administration Record (MAR)," dated November 2023, indicated the R103 had received the nebulizer treatment from RN6 on 11/23/23 during the 11-7 shift. During the next shift on 11/23/23 at	F 600	alleged deficient practice. 3. All staff were educated on the requirements of F600, utilizing the facility Abuse Policy and Procedure and means of reporting. 4. Social Services Director/designee will complete audits of 5 residents weekly x3 weeks until 100% compliance is achieved then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 7 6:12 PM, R103's daughter reported to the Licensed Practical Nurse (LPN) 8 that R103 received medication via the nebulizer mask which was very tight on R103s face and left red marks where the mask was. R103 and R103's daughter were crying and R103's daughter stated that R103 was afraid to stay at the facility due to the occurrence. A review of the facility incident report, provided by the facility, revealed that it was submitted to the state agency on 11/24/23 and indicated that R103 was found with red scratches/marks to her face and was fearful of RN6. RN6 failed to appropriately assess and recognize signs and symptoms of pain/discomfort and continued to provide care despite R103 attempting to resist. RN6 failed to follow physician's orders for care and did not discontinue treatment or switch to another treatment modality when R103 started to resist care. RN6 was suspended on 11/24/23 prior to working another shift and was eventually terminated on 11/29/23 at the conclusion of the facility investigation. During an interview on 11/22/24 at 10:00 AM, the Director of Nursing (DON) stated that she remembered the incident and that RN6 was immediately suspended while the facility was investigating what happened. The DON also stated that during the course of the investigation RN6 was interviewed on a couple of occasions and the description of what happened was inconsistent. The DON stated on 11/29/23, RN6 was terminated for the alleged abuse. 2. Review of R39's annual "MDS" located under the "MDS" tab of the EMR with an ARD of 10/25/23, revealed the resident had a BIMS score	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 8	F 600		

of 15 out of 15 which indicated the resident was cognitively intact. The resident received hospice care and passed away on 11/16/24.

Review of R39's written statement, dated 10/14/24 and provided by the facility, revealed that R39 has had multiple "altercations with CNA [Certified Nurse Aide (CNA) 12] but we always make up." R39 stated that they could hear CNA treat other patients and was scared to say anything to get CNA in trouble. I used the call bell around 8:30 AM and told CNA that I had a bowel movement. CNA stated "I'm busy and will come back later. I waited 20 or 30 minutes. Ring the call bell again." CNA stated, "Why did you hit the call bell again, I told you I was coming back-I'm buried." Could hear CNA screaming in the hallway but could not make out what was being said. "I was very upset; I did keep hitting the call bell because CNA would not change me. Stated that she was too busy."

During an interview on 11/21/24 at 12:45 PM, CNA9 agreed that the written statement (The email regarding CNA12), dated 10/15/24, about the involvement with R39 and CNA12 was accurate and truthful. CNA9 stated that CNA12 did state "Somebody better come and get resident before I punch resident in the face."

During the interview on 11/21/24 at 1:05 PM, LPN7 confirmed an investigative report, dated 10/12/24, into the involvement with R39 and CNA12 was accurate and truthful. LPN7 stated CNA12 told her "Somebody better come and get resident before I punch resident in the face." She stated that CNA12 further stated "I didn't mean anything." LPN7 stated the allegation was substantiated. She stated the disciplinary action

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 9	F 600		

was termination, but CNA12 resigned via email on 10/15/24. LPN7 stated R39 was informed of the outcome of the investigation and answered all questions.

During the phone interview on 11/21/24 at 1:38 PM, CNA12 confirmed that the written statement, dated 10/15/24, about the involvement with R39 was accurate and truthful. CNA12 explained: "I was just frustrated and lashing out. I was little burnt out, and I take full responsibility for my actions. I wasn't even by the resident's room."

During an interview on 11/21/24 at 1:00 PM, the Social Services Director (SSD) stated that R39 had periods where CNA12 was not kind. SSD stated that R39 said CNA12 asked to be taken cff his assignment.

3. Review of R105's "Admission Record" locatec in the "Profile" tab of the EMR revealed R105 was admitted to the facility on 01/29/24 with diagnoses that included a urinary tract infection, lumbar (lower spine) fracture, and seizures.

Review of the admission "MDS" located in the "MDS" tab of the EMR with an ARD of 02/04/24 revealed R105 had a "BIMS" score of 15 out of 15 which indicated she was cognitively intact for daily decision-making.

Review of a "Progress Note," dated 02/22/24 and located in the "Progress Notes" tab of the EMR, revealed " ...Discharge Plan: SW (social worker) met with resident, Resident requesting to go home. Resident stated she feels like her mental health cannot get better in rehab. Rehab director explained that resident could use additional time, resident refused. SW spoke with resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 10 caregivers who agreed to discharge for 2/23/24 ..." Review of a "Facility Abuse Investigation," dated 02/23/24 and provided by the DON, revealed " ...02/22/2024 @ 10:30 AM ...Abuse, Mistreatment ...Accused: Staff ...Resident stated her cna (sic) disrespected her made her feel demoralized and throws clothing at her when it is time to get dress (sic). Resident stated cna (sic) points her finger (does not speak) and motions when she want (sic) resident to turn over. Also stated cna (sic) is loud in the hallways (shouting). Resident stated its not good for my mental health. Resident afraid of retaliation. The resident is clear and consistent in naming [CNA13] as the cna." Outcome of the investigation revealed, "[CNA13] was suspended pending investigation on 02/22/24 and was terminated on 02/28/24, for interfered (sic) with an ongoing resident concern investigation, disrespectful conduct on nursing unit in front residents, staff, and family (towards administrator) and inappropriate interactions considered verbal intimidation. [R105] was informed of the outcome of the investigation." During an interview on 11/22/24 at 11:23 AM, Human Resources (HR) was asked to define verbal intimidation in the investigation. HR stated, "Verbal intimidation is considered verbal abuse in our eyes." During an interview on 11/22/24 at 1:02 PM, the DON stated she hadn't looked at the investigation in some time, but the allegation of abuse was substantiated.	F 600		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12	F 602		1/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 11 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to protect two of two residents (Residents (R) 17 and R95) from misappropriation of property of 40 sample residents. This failure has the potential to affect all residents who choose to keep money and/or credit cards in their rooms. Findings include: Review of the facility's policy titled, "Abuse, Neglect, Mistreatment, Misappropriation, Exploitation and Reasonable Suspicions of Crime" indicated the following: " ...Misappropriation of resident property is the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent." 1. Review of R17's "Resident Profile" located in the electronic medical record (EMR) under the "Resident" tab, indicated R17 was admitted to the facility on 06/12/21 with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, obstructive sleep apnea, diabetes mellitus due to underlying condition with diabetic chronic kidney disease,	F 602	F602 1. R17 received her credit card statement for July 2024 with charges on it that she didn't make. She reported this to the state and police. She stated a Certified Nurse Aide (CNA) 16 who worked at the facility stole the card. The DON started an investigation was completed and CNA16 was terminated. R95 stated a credit card was stolen and a charge for $45 was on the card that he did not make. He stated the card was locked by the bank. An investigation was immediately started and the employee was terminated. The incident was reported to the state and police. 2. All residents have the potential to be affected by this alleged deficient practice, no other residents were identified as having negative outcomes. 3. A full house sweep of resident rooms was completed to ensure that valuables were secured for those that accepted. 4. Social Services Director/designee will complete audits of 5 residents weekly x3 weeks until 100% compliance is achieved. then monthly x 3 months with a goal of 100% is achieved and sustained. In an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 12 and muscle weakness. Review of the annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 09/09/24 revealed R17 had a "Brief Interview for Mental Status (BIMS)" score of 11 out of 15 which indicated the resident was moderately cognitively impaired. During an interview on 11/19/24 at 1:55 PM, the Director of Nursing (DON) stated R17 received her credit card statement for July 2024 with charges on it that she didn't make. She reported this to the state and police. She stated a Certified Nurse Aide (CNA) 16 who worked at the facility stole the card. The DON stated an investigation was completed and CNA16 was terminated. During an interview on 11/19/24 at 3:45 PM, R17 stated she believed the credit card number was taken off the bill she had on her dresser. She stated there were eight to 10 unauthorized charges on the bill. She stated she did not know who took the credit card number and used it. R17 stated the facility administrative staff reported this issue to her about her card being used. She denied any further issues since that time. Review of the "[Facility Name] General Orientation Record" provided by the Administrator, revealed CNA16 received education on 06/20/24 regarding abuse, neglect, exploitation, and misappropriation of resident property. 2. Review of R95's "Admission Record" located under the "Resident" tab of the EMR revealed R95 was admitted on with diagnoses of malignant neoplasm of colon, cellulitis, secondary malignant	F 602	event where compliance is consistently below the goal, the Interdisciplinary (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 13	F 602		

neoplasm of liver and intrahepatic bile duct, and major depressive disorder.

Review of the significant change "MDS" with an ARD of 08/27/24, revealed R95 had a BIMS of eight out of 15 indicating the resident was moderately cognitively impaired.

During an interview on 11/19/24 at 11:56 AM, R95 stated a credit card was stolen and a charge for $45 was on the card that he did not make. He stated the card was locked by the bank.

Review of CNA16's employee file revealed she was observed on camera picking up the food she purchased with stolen credit cards from the residents. On 07/22/24, the Administration team was informed a resident was missing a sum of money from a bank account. Purchases were made on 07/19/24 and 07/20/24 from the restaurant in question and delivered to the facility.

Review of CNA16's termination letter revealed the following: "Under Delaware Title 16, this is defined as "Financial exploitation' [...] the illegal or improper use of a patient's or resident's resources for financial rights by another person, whether for profit or other advantage."

Review of the facility "Incident Report," dated 10/03/24 and provided by the facility, revealed video recordings of CNA16 picking up the food.

During an interview on 11/19/24 at 1:55 PM, the DON stated the perpetrator used R95's debit card on two separate occasions 07/19/24 and 07/20/24. She stated the resident, and his sister confirmed there were unauthorized charges on the debit card. The DON stated the facility had

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 14 completed an investigation and reported the incident to the police. Review of CNA16's written statement, dated 07/31/24 and provided by the facility, indicated CNA16 stated the food items were ordered and her phone number was used. During an interview on 11/22/24 at 7:43 AM, The DON stated residents could secure their money, credit cards, and valuables in their nightstands. She stated maintenance could put a lock on the drawer and provide a key to the residents.	F 602		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609		1/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 15 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, the facility failed to ensure that an allegation of potential abuse was reported to the State Survey Agency (SSA) in a timely manner for one of five residents (Resident (R) 108) reviewed for abuse/neglect of 40 sample residents. This failure had the potential for other allegations of abuse/neglect not to be reported in a timely manner. (Cross Reference F741) Findings include: Review of a facility's policy titled, "Abuse, Neglect, Mistreatment, Misappropriation, Exploitation and Reasonable Suspicions of Crime" dated 10/19 indicated " ...Witnessed or suspected incidents of abuse are to be reported immediately ...neglect, mistreatment ... Allegations of resident abuse shall be reported to the appropriate state regulatory authority within 2 hours ..." Review of R108's electronic medical record (EMR) titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on 06/09/21 with a diagnosis of dementia. Review of R108's EMR quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/26/23 indicated the facility staff could not determine the resident's "Brief Interview for	F 609	F609 1. Certified Nurse Aide (CNA) 1 informed the MDS Coordinator (MDSC) that R108 sustained a skin tear during the provision of care. The MDSC identified skin tears and multiple bruised areas on the resident's bi-lateral arms and wrists. The incident was reported to Delaware Health & Social Services Division of Health Care Quality at 11:14pm when the alleged action took place at 7:30pm. The physician and the resident□s responsible party were notified promptly upon completion of the assessment. A thorough investigation was initiated by the Director of Nursing Services and the facility Administrator. 2. All residents have potential to be affected by stated deficiency; no similar findings and/or negative effects have been identified by this alleged deficient practice. 3. All staff Nurses were educated on the requirements of F609, Reporting of Alleged Violations. Specifically, this education focused on the facility□s responsibility to ensure alleged violations involving misappropriation, neglect and/or abuse are immediately reported to the Administrator, DON, and respective State	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 16 Mental Status (BIMS)" score and revealed the resident had short-and-long-term memory problems. The assessment indicated the resident had no behavior during this assessment period. The assessment indicated the resident required one staff member's assistance for toileting. Review of R108's EMR "Care Plan" located under the "Care Plan" tab, dated 12/04/21, indicated the resident had a self-care deficit related to dementia. The care plan interventions revealed when the resident was incontinent, she required partial/moderate assistance from staff with hygiene. Review of a document provided by the facility titled, "Alleged Abuse," dated 10/13/23, indicated Certified Nurse Aide (CNA) 1 informed the MDS Coordinator (MDSC) that R108 sustained a skin tear during the provision of care. The MDSC identified skin tears and multiple bruised areas on the resident's bi-lateral arms and wrists. Review of a document provided by the facility titled, "Delaware Health & Social Services Division of Health Care Quality," dated 10/13/23, revealed the facility determined on 10/13/23 at 7:30 PM the incident between CNA1 and R108 was a potential allegation of mistreatment. The document indicated the allegation was reported to the SSA on 10/13/23 at 11:14 PM. During an interview on 11/20/24 03:12 PM, the MDSC confirmed she was the staff member who completed the initial skin assessment of R108. The MDSC stated she escalated the staff to resident incident due to potential abuse and reported the allegation immediately to the Director of Nursing (DON). The MDSC stated the	F 609	Agency as indicated. 4.The Director of Nursing Services/designee, will conduct a random audit of five (5) residents weekly x3 weeks until 100% compliance is achieved then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 17 allegation was to be reported to the SSA within two hours but failed to do so. During an interview on 11/22/24 at 1:06 PM, the Administrator stated any allegation of abuse/mistreatment was to be reported to the SSA within two hours.	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure one of one resident (Resident (R) 36) of 40 sample residents had an accurate "Minimum Data Set (MDS)" assessment. Failure to code the "MDS" correctly could potentially lead to inaccurate federal reimbursements and inaccurate assessment and care planning of the residents. Findings include: Review of the RAI manual, dated 10/24 and located at Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual | CMS, revealed " ...It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary] completing the assessment. As such, nursing homes are responsible for ensuring	F 641	F641 1. MDS was modified 11/21/2024 and resubmitted on 11/26/2024. 2.All residents have potential to be affected, no similar findings and/or negative effects have been identified. 3.The MDS staff in-service on completed MDS accuracy of assessment. 4. MDS coordinator/designee will complete random audits of 5 MDS weekly x3 weeks until 100% compliance is achieved then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	1/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 18	F 641		

that all participants in the assessment process have the requisite knowledge to complete an accurate assessment ..."

Review of R36's electronic medical records (EMR) "Admission Record" located under the "Profile" tab indicated the resident was admitted on 08/10/17.

Review of R36's EMR nursing "Incident Report" progress note located under the "Prog (Progress) Note" tab, dated 07/18/24, indicated that a Certified Nurse Aide (CNA) alerted the nurse that R36 sustained a fall from her wheelchair. According to the progress note, the CNA informed the nurse that she was getting the resident ready for bed and before she could get to the resident, the resident tossed a pillow and fell from her wheelchair and hit her head. The nurse notified the physician, and the physician informed the nurse to have the resident transported to the local hospital.

Review of R36's EMR nursing "Incident" progress notes, located under the "Prog Note" dated 7/18/24, indicated a CNA alerted the nurse that the resident fell from her wheelchair onto the floor. The progress notes indicated the resident sustained swelling to her forehead. The physician was notified and ordered that the resident be sent to the local hospital for evaluation and treatment.

Review of R36's EMR nursing "Admission" progress notes, located under the "Prog Note" tab, dated 07/24/24, indicated the resident returned from the hospital.

Review of R36's EMR significant change "MDS" with an Assessment Reference Date (ARD) of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ____ B. WING ____	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 19 08/08/24 indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of zero out of 15 which revealed the resident was severely cognitively impaired. The assessment failed to address that the resident sustained a fall during this assessment period. During an interview on 11/21/24 at 12:25 PM, the MDS Coordinator (MDSC) verified that the significant change MDS did not reflect R108's fall sustained on 07/18/24. The MDSC stated the purpose of the resident's significant change MDS was related to the fall that the resident sustained.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: ."Based on observations, interviews, and record review, the facility failed to ensure activities of daily living (ADLs) were provided consistently according to the plan of care for two of six residents (Residents (R) 93 and R23) reviewed for ADLs of 40 sample residents. The facility failed to ensure R23 was provided with oral hygiene and R93 was provided with consistent showers twice weekly. This failure placed the residents at risk of a diminished quality of life. Findings include: 1. Review of R93's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R93 was admitted to the facility	F 677	F677 1. 1. The facility does not have the ability to retroactively address the documentation for R93 showers. 2.Audit completed of all resident□s shower schedules per facility policy. 3.Unit managers/designee will monitor all bath/showers and POC documentation each shift. All direct care staff will be in-service by Staff Developer/designee on standard of care and documentation completion. 4. Unit manager/designee will complete daily audit will be conducted x1 week to ensure accuracy until 100% compliance is	1/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 20 on 10/27/23 with diagnoses that included dementia. Review of the annual "Minimum Data Set (MDS)" located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of 10/26/24 revealed that R93 had a "Brief Interview for Mental Status (BIMS) score of zero out of 15 which indicated R93 was severely impaired in cognition. Review of the "ADL Care Plan" located in the "Care Plan" tab of the EMR, initiated on 04/17/24 and revised on 05/04/24, revealed "[R93] has an ADL self-care performance deficit r/t [related to] dementia and functional quadriplegia (complete immobility due to severe disability or frailty). Review of the "Point of Care (POC-Certified Nurse Aide (CNA) documentation" located in the "Tasks" tab of the EMR, revealed that R93's showers were not documented as having been done or if the resident had refused on the following dates: 08/22/24, 09/02/24, 09/19/24, 10/03/24, 10/10/24, 10/14/24, 11/04/24, 11/07/24, 11/11/24 and 11/14/24. There was no documentation of the resident receiving or refusing bed baths. During an interview on 11/21/24 at 12:48 PM, Licensed Practical Nurse (LPN) 4 was asked how she monitored resident showers to ensure they were being given, according to the "Plan of Care." LPN4 stated, "When a shower is not given, the nurse is to be informed. If a shower is refused, we would go to the residents and ask why they are refusing. If they continue to refuse, it is documented, and the family is notified." LPN4 further stated that R93's shower days were	F 677	achieved and sustained. Weekly audit x3 weeks until 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. 2. 1.The facility does not have the ability to retroactively address the R23 oral care not completed. 2.All residents have potential to be affected. Audits completed to ensure all residents have oral care supplies at bedside. 3.Unit managers/designee will in-service all direct care staff on standard of care and accuracy of documentation. 4. Unit manager/designee will complete daily audit will be conducted x1 week to ensure accuracy until 100% compliance is achieved and sustained. Weekly audit x3 weeks until 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 21 Monday and Thursday on the 3:00 PM to 11:00 PM shift. During an interview on 11/21/24 at 3:12 PM, CNA13 was asked what her process was with regards to making sure residents received their showers. CNA13 stated, "I get my shower assignment when I come on duty which is in the assignment book. If a resident takes the shower and/or refuses, I tell the nurse, and it's documented in the POC. I can't answer as to why his showers were not done." During an interview on 11/22/24 at 10:29 AM, Unit Manager (UM) 1 stated, "I went over the showers that were documented for [R93] and found the days he did not get his showers, this was a problem." UM1 was asked what her expectation was regarding ensuring residents received their showers according to the "Care Plan." UM1 stated, "My expectation is that residents receive their showers according to the schedule and the nurses are informed when there is a refusal." During an interview on 11/22/24 at 12:45 PM, the Director of Nursing (DON) stated, "The resident showers are to be documented if given and if there is a refusal, to let the nurse know so they can speak to the resident." 2. Review of R23's "Admission Record" located in the "Profile" tab of the EMR revealed R23 was admitted to the facility on 07/07/22 with diagnoses that included a stroke with right-sided paralysis and vascular dementia. Review of the quarterly "MDS" assessment located in the "MDS" tab of the EMR with and ARD of 10/11/24 revealed, R23 had a "BIMS"	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 22 score of 15 out of 15 which indicated she was cognitively intact for daily decision-making. In addition, R23 had limited range of motion on both upper and lower extremities on one side. Review of the "Dental Care Plan" located in the "Care Plan" tab of the EMR, dated 10/15/22 and revised on 04/22/23, revealed "[R23] has own natural teeth with breakdown and is at risk for complications. She had a tooth extracted on 03/29/23." A 10/15/22 approach revealed "Provide mouth care as per ADL personal hygiene." Review of the "ADL Care Plan" located in the "Care Plan" tab of the EMR, dated 07/14/22 and revised on 06/27/24, revealed "[R23] has an ADL self-care performance deficit r/t Dementia, Impaired balance, Limited Mobility, Stroke." There were no documented approaches for oral hygiene on the "ADL Care Plan." During an observation and interview on 11/19/24 at 1:34 PM, R23 was observed to have a significant amount of brown coating across both her upper and lower teeth. R23 was asked if staff assisted her to brush her teeth. R23 stated, "Sometimes they do." Review of the "POC Response History-Oral Hygiene" located in the "Task" tab of the EMR, revealed that R23 was dependent on staff (Dependent is defined as Helper does all of the effort and resident does none of the effort to complete the activity) in order to meet her oral hygiene needs. Documentation showed that from 07/21/24 to 11/21/24 (124 days) R23 required only set up assistance once, required supervision for four opportunities, partial or moderate	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 23 assistance for four opportunities, extensive assistance for seven opportunities, and was dependent on staff for oral hygiene for 208 opportunities. During an observation and interview on 11/22/24 at 10:33 AM, UM1 observed R23's teeth. UM1 confirmed that her teeth had not been brushed and there was a coating on her teeth. UM1 further stated, "It's been a while since her teeth were brushed." During an interview on 11/22/24 at 12:52, the DON stated, "[R23] can brush her own teeth after staff put the toothpaste on her electric toothbrush." The DON was informed that the documentation in POC revealed that R23 was dependent on staff for oral hygiene. The DON stated, "She should be extensive assistance and not dependent on staff."	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure one Licensed Practical Nurse (LPN) 1, who identified a skin alteration for one of two	F 684	F684 1.Physician order was obtained and R36 was seen by the wound care team on 11/21/24, treatment put in place for right	1/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 24 residents (Resident (R) 36's) reviewed for wound care, notified the Primary Care Physician (PCP) for treatment orders. In addition, the facility failed to ensure a physician ordered blood pressure was obtained prior to administering a hypertensive medication for one of five residents (Resident (R) 109) observed during the medication pass of 40 sample residents. This failure placed residents at risk for health complications. Findings include: Review of the facility's policy titled, "Provider Notification of Resident Change in Medical Condition," dated 04/17, indicated " ...It is the policy of [Facility Name] Rehabilitation and Healthcare Center that staff communicate changes in a resident's medical condition to providers in a timely and accurate manner ..." Review of the facility's undated policy titled, "Pressure Ulcer Identification" indicated " ...Resident will be assessed for timely identification and interdisciplinary intervention for the care and treatment of pressure ulcers. . .New wound alert form will be completed by the nurse identifying the wound and forward as indicated ..." Review of the facility's policy titled, "Medication Administration," dated 2023, revealed " ...Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection ...Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs	F 684	ankle abrasion. 2.All residents have potential to be affected. Audit of wound care orders complete to ensure correct orders are written. 3.All licensed nursing staff will be in-service on order entry. 4. Unit manager/designee will complete random audits on 10 resident records Weekly audit x3 weeks until 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 25 outside the physician's prescribed parameters ...Compare medication source (bubble pack, vial, etc.) with MAR (Medication Administration Record) to verify resident name, medication name, form, dose, route, time ..." 1. Review of R36's electronic medical record (EMR) "Admission Record" indicated the resident was admitted to the facility on 08/10/17. Review of R36's EMR "Care Plan" located under the "Care Plan" tab, dated 09/19/24, indicated the resident had an unstageable pressure ulcer on the right heal related to the disease process, poor nutritional intake, and immobility. No mention of the right ankle abrasion. Review of R36's EMR significant change "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/12/24 indicated the staff could not determine the resident's "Brief Interview for Mental Status (BIMS)" score and determined the resident had short-and-long-term memory problems. The assessment indicated the resident had no impairments on her upper and lower body extremities. The assessment revealed R36 was dependent on staff for activities of daily living. Review of R36's EMR "Order Note," dated 11/19/24, revealed LPN1 noted a new wound to the resident's right ankle. Review of R36's EMR physician "Orders" located under the "Orders" tab failed to indicate orders were obtained to treat the new wound on the resident's right ankle. Review of a document provided by the facility	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 26	F 684		

titled "Physician Communication Record" for R36 failed to indicate LPN1 communicated to the resident's primary care physician (PCP) the new wound identified on the resident's right ankle.

During an interview on 11/21/24 at 8:25 AM, Registered Nurse (RN) 4 stated R36's boot was taken off daily for hygiene.

During an observation and interview on 11/21/24 at 8:30 AM, RN5 (who was the facility's wound nurse) and the Wound Doctor entered R36's room. The resident was in her bed. The Wound Doctor lifted the blankets from the resident's lower leg and removed a white removeable splint from the right leg. The Wound Doctor treated the resident's right. After the dressing was applied to the resident's right ankle, the Wound Doctor stated there was a skin abrasion on the resident's right ankle and was not aware of the abrasion. The Wound Doctor stated the abrasion was caused by the leg splint. There was no dressing observed on the resident's right ankle. The Wound Doctor stated he was going to treat the resident's right ankle like it was a wound.

During an interview on 11/21/24 at 11:29 AM, RN5 confirmed she was notified of R36's abrasion of her right ankle today and was informed of the area by the Director of Nursing (DON). RN5 went through the resident's EMR and confirmed there were no orders to treat the right ankle abrasion. RN5 stated the expectation for a new skin area was to notify the physician and begin treatment.

During an interview on 11/21/24 at 11:49 AM, R36's PCP was interviewed, and she stated she did not remember being notified of the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 27 right ankle abrasion. During an interview on 11/21/24 at 4:02 PM, LPN1 stated she just completed a skin assessment and did not make the resident's PCP or the wound team aware of the resident's right ankle. The DON was present during this interview and after the interview with LPN1, the DON stated LPN1 missed a few steps and did not notify the physician and the family, in addition, the DON stated a wound alert form was not completed. The DON stated the facility only had pressure ulcer policies and not general skin policies. 2. Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed that R109 was admitted to the facility on 11/07/24 with diagnoses that included hypertension and an irregular heart rhythm. Review of the "Physician Orders," dated 11/08/24 and located in the "Orders" tab of the EMR revealed, "Olmesartan [a blood pressure medication] give 20mg every day. Hold if SBP [systolic blood pressure] <120." During a medication pass observation on 11/21/24 at 8:50 AM, LPN7 was observed to have punched out the medication from a bubble pack, and along with her other medications, proceeded to enter R109's room to administer the medication. LPN7 was stopped and asked if she had obtained R109's blood pressure prior to administration per the label on the bubble pack. LPN7 stated, "It's not on her MAR [medication administration record] and does not pop up to alert us not to give the medication without obtaining a blood pressure."	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ____ B. WING ____	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE** **WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 28 Review of the blood pressures documented in the "Weights and Vitals" tab of the EMR from admission, with LPN7, revealed no documented blood pressures had been obtained at the time the medication was administered on nine occasions. The blood pressures had been obtained on the night shift however, it was not taken on the day shift when the medication was administered. LPN7 confirmed that the blood pressures had not been obtained prior to administration on the day shifts. During an interview on 11/21/24 at 9:38 AM, the DON stated, "The "Physician Order does indicate holding the medication if the SBP <120 as well as on the MAR." The DON confirmed that the "heart" icon on the MAR was missing which would have allowed the nurses to document the blood pressure prior to administration. The DON further stated that after the physician entered the medication into the system, RN7 would have to confirm the order however, she did not include the supplemental documentation to include blood pressure. During an interview on 11/21/24 at 3:47 PM, RN7 confirmed that she did not include the supplemental documentation in the system to include holding the medication if the SBP was <120. During an interview on 11/22/24 at 9:51 AM, the Pharmacist stated that R109 was a new admission, so her medication review had not been done. The Pharmacist further stated, "When I do my medication cart rounds and see the discrepancies, I would bring that information to administration via my reports."	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687	Continued From page 29	F 687		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews, and facility policy review, the facility failed to ensure nail care was provided to one of one resident (Resident (R) 1) reviewed for nail care of 40 sample residents. This had the potential to limit mobility for R1 or cause R1 pain if the nails were left untreated. Findings include: Review of the facility's policy titled, "Nails, Care of Finger and Toe," dated May 2023, indicated " ... PURPOSE ... To provide cleanliness ... To prevent spread of infection ..." Review of an undated "Face Sheet," provided by the facility, indicated R1 was admitted to the facility on 09/12/24, with diagnoses of abnormalities gait, muscle weakness, and lack of mobility. Review of the five day "Minimum Data Set	F 687	F687 1.Resident was set up for podiatry consult on discovery. 2.An audit of all residents to ensure consents were signed for podiatry services. 3.An in-service education program was conducted by the Unit managers/Supervisors with all direct care staff addressing the need for podiatry consult. 4. Unit Managers/designee on each unit will monitor the toenails for all residents. The Director of Nursing Services/designee, will conduct a random audit of at least five (5) residents weekly x3 weeks until 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the	1/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING _____ B. WING _____	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687	Continued From page 30 (MDS)" with an Assessment Reference Date (ARD) of 10/24/24 revealed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 which indicated R1 was cognitively intact. The assessment revealed R1 required limited assistance of one staff member for personal hygiene. During an observation conducted on 11/20/24 at 11:05 AM, R1 removed bed sheets to expose lower extremities, including the feet. On both feet, the toenails were uncut, and the nails extended beyond the tip of the R1's toes. During an interview on 11/20/24 at 11:23 AM, R1 stated that since being admitted to the facility, she had been requesting a podiatry appointment. She could not remember who she asked, but R1 stated that she had asked several staff members. During an observation and interview conducted on 11/21/24 at 9:15 AM, R1's bed sheets were removed to expose lower extremities, including the feet. On both feet, toenails were uncut, and the nails extended beyond the tip of the R1's toes. Registered Nurse (RN) 5 was unaware that both left and right foot nails were uncut to where they extended beyond the tips of the R1's toes. During an interview on 11/21/24 at 9:15 AM, RN5, stated staff would ask if residents required podiatry care and gave the referrals to her. RN5 stated she would make podiatry appointments at that time. She stated the facility used podiatry because staff did not cut toenails. RN5 stated that R1 did not complain about her toenails, nor did any staff member tell her about R1 needing podiatry. RN5 stated if a resident needed to have their toenails done, she would make the appt.	F 687	Interdisciplinary (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687	Continued From page 31 During an interview on 11/21/24 at 7:29 AM, Certified Nurse Aide (CNA) 17 confirmed staff could not trim a resident's toenails. CNA17 stated she informed RN5 when a resident needed their toenails trimmed, and RN5 would make the appointment. CNA17 also stated that R1 told her that an appointment had been made for her toenails. She stated that it was about two weeks ago. CNA17 stated she did not tell anybody about the conversation or follow up if this was done. During an interview on 11/21/24 at 7:45 AM, CNA18 who had completed personal care for R1 confirmed not knowing R1's toenails needed trimming. During an interview on 11/21/24 at 8:05 AM, CNA19 who had completed personal care for R1 confirmed not knowing R1's toenails needed trimming. During an interview on 11/22/24 at 12:21 PM, the Director of Nursing (DON) stated the facility made appointments for podiatry. She stated the facility required all residents to be seen by a podiatrist. She also stated the facility audited skin frequently and the goal for nail care was to prevent infection.	F 687		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		1/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 32 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, interviews, and review of facility policies, the facility failed to ensure one resident (Resident (R) 36) was provided adaptive equipment (padded footrest) that was attached to her wheelchair and failed to ensure one of two residents (R23) was consistently provided with a physician ordered splint to her right arm/hand of 40 sample residents. This failure placed the residents at risk of improper support, positioning, and at risk of further decreased range of motion (ROM) and worsening contractures (a condition of shortening and hardening of muscles, tendons, and other tissue, often leading to deformity and rigidity of joints). Findings include: Review of the facility's policy titled, "Repositioning," dated 03/16, indicated " ...Lifting/handling and other assistive devices will be used whenever determined based on the practitioner order ..." Review of the facility's policy titled, "Splints and Position Devices," dated 05/16, indicated " ...All	F 688	F688 1.Both residents R36 and R23 were adjusted to have the ordered adaptive equipment 2.An audit of all residents who have ordered adaptive equipment was completed to ensure each resident had the appropriate devices as ordered 3.Mesh bags will be purchased to ensure all splints are stored appropriately and wheelchair storage bags to be purchased to store wheelchair adaptive equipment. Care plans to be updated to reflect accuracy. 4. Unit Managers/designee on each unit will complete audits of residents who have orders for adaptive equipment weekly x3 weeks until 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 33 residents are screened by therapy on admission for contractures and/or limitations in range of motion. . .Based on evaluation, specialized devices, such as, knee immobilizers or custom splinting may be requested through the Rehabilitation Department. Rehab will obtain these devices and provide instructions on application ..." 1. Review of R36's electronic medical record (EMR) "Admission Record" located under the "Profile" tab of the EMR indicated the resident was admitted to the facility on 08/10/17. Review of R36's EMR "Incident Note" located under the "Prog Notes" tab, dated 07/25/24, revealed the resident was identified with a fracture of her right tibia/fibula. The resident was sent to the local hospital and returned back to the facility on the same date, with conservative treatment ordered (no surgical repair per family request). Review of a document provided by the facility titled "Physical Therapy Treatment Encounter Note," dated 07/29/24, indicated R36 was seen sitting in her wheelchair and her leg rests were adjusted and it was noted by the physical therapist, that the resident would take her legs off the leg rests and recommended a calf and foot board to allow relaxation of her legs on the leg rests and to avoid further trauma to the resident's lower extremity. Review of a document provided by the facility titled, "Occupational Therapy Treatment Encounter Note," dated 07/29/24, indicated R36 was provided with a high back reclining wheelchair with elevating leg rests and seat	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 34	F 688		

cushion to promote proper positioning and postural alignment during out of bedtime ..."

Review of R36's EMR "Care Plan" located under the "Care Plan" tab, dated 10/28/24, indicated the resident had limited physical mobility related to muscle weakness. The care plan failed to address the resident required the use of a high back wheelchair and a padded footrest to assist the resident with positioning.

During an observation on 11/19/24 at 3:46 PM, R36 was sleeping in her high back wheelchair. There was a Roho cushion on the seat of the wheelchair, and there were padded footrests attached to the feet of the wheelchair.

During an observation on 11/20/24 at 1:55 PM, R36 was observed sitting in a standard wheelchair and no padded footrests were attached to the feet of the wheelchair.

During an observation and interview on 11/20/24 at 5:06 PM the Director of Rehabilitation (DOR) stated R36 was picked up for skilled therapy by Physical and Occupational therapies after her fracture was identified. The DOR confirmed the therapy department recommended a padded footrest for the resident after her hospital stay. At 5:17 PM, the DOR and surveyor went up to the Dementia Unit and observed the resident in the main dining room, sitting in a standard wheelchair and confirmed the resident did not have padded footrests attached. The resident was observed with a brace on her right lower leg, and it was resting on one of the footrests. The left foot had dropped between the two footrests. At 5:18 PM, Certified Nurse Aide (CNA) 2 (day shift) confirmed she did not have R36 placed in a high

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING _______ B. WING _______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 35 back wheelchair and did not place the padded footrests on the standard wheelchair. The DOR was present during this interview. Registered Nurse (RN) 4 was present during this observation and interview. An interview was conducted at 5:18 PM, with CNA3 (works the evening shift) and stated the resident typically had footrests on the wheelchair but did not know why they were not presently on the resident. At 5:19 PM, DOR and the surveyor entered R36's room and found her high back wheelchair in the bathroom along with the padded footrests. During an interview conducted on 11/20/24 at 5:23 PM, the DOR stated the padded footrests were for positioning as well as the high back wheelchair. During an interview on 11/20/24 at 5:27 PM, RN2 stated R36 required the use of padded footrests. RN2 went into R36's EMR and verified that there was no reference in the Treatment Administration Record (TAR) which would potentially track placement of the resident's padded footrests. During an interview on 11/20/24 at 6:03 PM, the DOR stated R36's high back wheelchair allowed the resident for a more comfortable position. The DOR stated the padded footrests would prevent the resident's feet from slipping past the footrests and allowed the resident to have proper sitting and positioning with the ankle and foot. 2. Review of R23's "Admission Record" located in the "Profile" tab of the EMR revealed R23 was admitted to the facility on 07/07/22 with diagnoses that included a cerebral vascular accident (CVA-stroke) with right-sided paralysis.	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 36 Review of a "Physician Order" dated 03/04/24 and located in the "Orders" tab of the EMR revealed, "Right hand splint to be applied at HS [hour of sleep] and worn throughout the night-if resident complains of pain or discomfort, it is ok to remove splint A and apply splint B. If splint A needs to be removed for comfort, the splint should be sent to her OT [occupational therapist] for any modifications that might need to be made." Review of a "Physician Order" dated 03/05/24 and located in the "Orders" tab of the EMR, revealed "Splint A to be worn 6-8 hours during the day. Apply Splint A in the morning at 0900 [9:00 AM]. Remove Splint A at 1700 [5:00 PM] and perform a skin check to area. Notify MD [Medical Doctor] of any redness or irritation caused by the splint." Review of the quarterly "Minimum Data Set (MDS) located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of 10/11/24 revealed R23 had a "Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R23 was cognitively intact for daily decision-making and had limited range of motion on one side involving both upper and lower extremities. Review of the "ROM Care Plan" located in the "Care Plan" tab of the EMR with an initiated date of 08/04/22 and revised on 10/14/24, revealed "[R23] has a moderate limitation of her right shoulder and right elbow. She also has moderate limitation of her right wrist and right ankle. Resident is at risk of developing new and/or worsening contractures and/or limitation in motion secondary to CVA and muscle weakness. Rehab	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 37	F 688		

assessment last completed on 09/17/24."

During an observation on 11/19/24 at 1:48 PM, R23 was sitting up in the recliner. There was no splint observed to her right arm and hand.

During an observation on 11/20/24 at 9:00 AM, R23 was in bed, and being assisted to eat. There was no splint on her right arm or hand.

During an interview on 10/21/24 at 10:21 AM, R23 was asked if the splint to her right arm/hand was applied consistently every morning. R23 stated, "Sometimes yes, sometimes no." R23 was asked if her nighttime splint was applied nightly. R23 stated, "Sometimes."

Review of the "Treatment Administration Record (TAR)" dated November 2024 and located in the "Orders" tab of the EMR, revealed from 11/19/24 to 11/22/24, Splint A was not documented as having been applied on 11/19/24 at 9:00 AM however, it was documented that Splint A was removed at 9:00 PM. On 11/20/24, 11/21/24, and 11/22/24, the documentation showed that Splint A was applied at 9:00 AM and removed at 9:00 PM.

During an interview on 11/22/24 at 10:44 AM, Unit Manager (UM) 1 was asked what her expectation was regarding splint placement. UM1 stated, "My expectation is that if there is a physician order for a splint/brace, then it needs to be applied." UM1 and this surveyor went to R23's room. UM1 confirmed that R23 did not have the splint on, as ordered.

During an interview on 11/22/24 at 12:52 PM, the Director of Nursing (DON) was told about the observations with R23 not having her splint on, as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 38 ordered. The DON stated, "My expectation is that nursing is to put the splint on, but she does refuse sometimes."	F 688		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to provide adequate assistance to ensure accidents were avoided for one of one resident (Resident (R) 102) reviewed for accident hazards of 40 sample residents. This failure had the potential to elevate the hazard/accident risk for all residents residing in the facility. Findings include: Review of the facility's policy titled, "Mechanical Lift (Hoyer and Stand), "dated January 2017 and provided by the facility, revealed "two staff members must be present to utilize a mechanical lift." Review of R102's "Admission Record" located in the electronic medical record (EMR) under the "Resident" tab, indicated R102 admitted on 10/06/20 with diagnoses of major depressive disorder, recurrent, mild, muscle weakness,	F 689	F689 1.The resident involved is no longer at the community 2.All residents have the potential to be affected about the deficient practice 3.Staff Developer/designee will in-service all direct care staff on proper use and handling of mechanical lifts and obtaining residents Kardex profile. Upon admission to the facility a chart review will be completed to ensure appropriate orders are obtained. 4. DON/designee will perform audit weekly x3 weeks until 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	1/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 39	F 689		

abnormal weight loss, unspecified dementia, anorexia, muscle wasting and atrophy.

Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 05/11/24 located in the EMR under the "Resident" tab, indicated R102 had a "Brief Interview for Mental Status (BIMS)" score of five out of 15 which indicated the resident was severely cognitively impaired.

Review of the "Physician Orders," dated June 2024 and located under the "Resident Tab" did not indicate how R102 should be transferred.

Review of the "Care plan" dated 05/03/24 and located under the "Care Plan" tab of the EMR, indicated R102 was "dependent assistance x2 staff members via Hoyer lift."

Review of the facility "Incident Report" dated 05/09/24 and provided by the facility, indicated Certified Nurse Aide (CNA) 6 transferred the resident alone and the resident's knees buckled. No injuries were sustained from the fall. R102 was care planned to be transferred via two persons using a Hoyer lift. CNA6 was suspended pending investigation. CNA6 was reported for neglect and was terminated from the facility.

During an interview on 11/20/24 at 1:29 PM, the Director of Nursing (DON) stated R102 was supposed be transferred via Hoyer lift. She stated any transfer requiring a mechanical lift should have two people present during the transfer.

During an interview on 11/22/24 at 11:05 AM, Licensed Practical Nurse (LPN) 4 stated she walked into R102's room and observed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 40 resident on the fall mat. She stated R102 denied hitting her head and, CNA6 confirmed R102 did not hit her head. LPN4 stated the resident was assessed and no injuries were noted. LPN4 and CNA6 assisted R102 to the chair using a Hoyer lift. LPN4 stated R102 was supposed to be transferred using a Hoyer lift. LPN4 reported the incident to her supervisor.	F 689		
F 741 SS=D	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.71. These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.71, and §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by:	F 741		1/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 741	Continued From page 41 Based on observations, record review, interviews, facility document review, and facility policy review, the facility failed to ensure residents were provided with appropriate dementia care interventions from one of one Certified Nurse Aide (CNA) 1 resulting in one of one resident (Resident (R) 108) sustaining harm with visible bruising, skin tears, and complaints of pain of 40 sample residents. This failure had the potential to affect resident safety at the facility. Findings include: Review of a facility's document titled "Facility Assessment," dated 10/22/24 and provided by the facility, indicated under a section titled "Staff Competencies" revealed " ...Competencies for Certified Nurse's Aides (CNA) include the following ...Behavioral Management ..." Review of a facility's policy titled, "Dementia Care," dated 2023, indicated " ...It is the policy of this facility to provide the appropriate treatment and services to every resident who has signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being ...The care plan will be achievable and the facility will provide resources necessary for the resident to be successful in meeting their goals ...Care and services will be person-centered and reflect each resident's individual symptomology ...All staff will be trained on dementia and dementia care practices upon hire, annually, and as needed to ensure they have the appropriate competencies and skill set to ensure residents' safety and help resident's attain or maintain the highest practicable physical, mental, and psychosocial well-being ..."	F 741	F741 1.Neither the resident nor staff are currently living/ working at the facility 2.All residents have the potential to be affected. 3.Education provided to team members on policies and procedures regarding Competencies including Dementia care. 4. HR/designee will complete audits upon hire and annually to ensure all team members receive dementia care training weekly x3 weeks until 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 741	Continued From page 42 Review of R108's electronic medical record (EMR) titled "Admission Record" located under the "Profile" indicated the resident was admitted to the facility on 06/09/21 with diagnoses that included dementia, mood disturbance, and anxiety. Review of R108's EMR quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/26/23 indicated the facility staff could not determine the resident's "Brief Interview for Mental Status (BIMS)" score and revealed the resident had short-and-long-term memory problems. The assessment indicated the resident had no behavioral issues during this assessment period. The assessment indicated the resident required one staff member's assistance for toileting. Review of R108's EMR "Care Plan" located under the "Care Plan" tab, dated 10/14/22, indicated the resident had a history of becoming physically aggressive with staff during the provision of care. The interventions of the care plan included attempting to provide an alternate time to provide care if refused, to remove the resident from the situation if she became agitated and utilize diversion techniques as needed. Review of a document provided by the facility titled "Alleged Abuse," dated 10/13/23, indicated Certified Nurse Aide (CNA) 1 informed the MDS Coordinator (MDSC) that R108 sustained a skin tear during the provision of care. The MDSC was the previous nurse supervisor on this date. According to the facility's investigation, R108 told the MDSC that she was grabbed and hurt. The MDSC documented the following injuries after CNA1's previous encounter: on the right upper	F 741		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 741	Continued From page 43 arm the resident sustained a skin tear which measured 1.2 centimeters (cm) by 0.3 cm; on the left hand the resident sustained two small skin tears which measured 0.5 cm by 0 cm and 0.5 cm by 0.1 cm; the resident sustained bruising on her right upper arm which measured 4.5 cm by 5 cm; the resident sustained bruising on her right forearm which measured 5 cm by 4.5 cm; the resident sustained bruising on her right wrist which measured 15 cm by 10.2 cm; and the resident sustained bruising on her left arm which measured 18 cm by 10.5 cm. The facility's investigation included a written statement provided by the facility from Licensed Practical Nurse (LPN) 1, dated 10/13/23. LPN1 documented she had returned from her lunch break and was asked by the MDSC to accompany her to R108's room. LPN1 documented both she and the MDSC assessed the resident's skin. LPN1 noted that the resident had bruising on her right and left wrists and her skin was red. LPN1 noted that R108 had a skin tear to her left wrist and complained of being in pain while the resident pointed to her bruises. LPN1 stated she medicated the resident with acetaminophen for her pain. As part of the facility's investigation, the MDSC asked CNA1 to complete a "Skin Tear Investigation," dated 10/13/23. CNA1 documented she held R108's wrists so she could clean between her legs. CNA1 wrote in her statement that the resident was confused, combative and slapped and hit her. CNA1 wrote that she was the one who caused the resident's skin tear during the provision of care. The facility immediately suspended CNA1 and began to interview multiple other staff about the incident.	F 741		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 741	Continued From page 44 A review of CNA1's employee record, provided by the facility, was conducted. The file indicated CNA1 was hired on 08/03/23. Review of a document provided by the facility titled, " Employee Status Change Notice" revealed CNA1 was terminated by the facility due to failure to provide R108, who had dementia, with proper dementia care as directed by the dementia care training she received from the facility. The document also indicated the resident sustained bruising on both arms and a skin tear. During an interview on 11/20/24 at 12:49 PM, Registered Nurse (RN) 4, stated if a resident was aggressive during cares, the CNAs were directed to make sure the resident was safe and to step away and approach the resident at another time. During an interview on 11/20/24 at 1:03 PM, CNA2 stated she remembered R108 and stated she was very sweet with staff who would speak to her in a kind manner. CNA2 stated if a resident was aggressive during care, the CNAs were directed to give her a break. CNA2 stated the resident was able to move around and stand with stand-by assistance. During an interview on 11/20/24 at 3:12 PM, the MDSC stated she was the staff member who CNA1 reported the skin tear to. The MDSC confirmed the resident was in pain and the bruises and the skin tear were evident. The MDSC stated R108 reported to her that a woman grabbed her, and the resident stated she did not know who the woman was. The MDSC stated residents with dementia could be pleasant or not so pleasant and require more patience from the staff. The MDSC stated that when a resident had	F 741		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 741	Continued From page 45 dementia, "we see their physical disabilities and we need caregivers who are understanding." The MDSC stated if a resident became combative during care, the staff were to ensure the resident was safe, leave, and then reapproach at a later time. The MDSC stated she had CNA1 demonstrate what happened, and per the MDSC, CNA1 grabbed her wrists to show this was what she did with R108. During an interview on 11/21/24 at 4:05 PM, the Director of Nursing (DON) stated CNA1 was trained in dementia care and worked with difficult behaviors. During an interview on 11/22/24 at 12:38 PM with the Administrator and DON, the Administrator stated it was important to have the caregiving staff trained in dementia care since that was the majority of the population in the facility. The Administrator stated CNA1 should have stopped care for R108 and walked away.	F 741		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		1/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 46 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of the facility policy, the facility failed to ensure the narcotic count sheets on each medication cart for the oncoming nurse and off going nurse were documented prior to finishing the narcotic count to ensure accuracy of the narcotics for five of five medication carts reviewed of 40 sample residents. This failure had the potential for drug diversion. Findings include. Review of an undated facility's policy titled, "Controlled Medication Storage and Accountability," revealed " ...Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with	F 755	F755 1.Narcotics books were updated with appropriate signatures. 2.No residents were identified as having been negatively impacted. Inservice provided to all licensed nurses on the policy for Controlled Medication storage and sign off. 3.A root cause analysis was completed by the IDT and it was identified that some licensed nurses failed to sign the narcotics signature sheets. Staff Developer/designee will provide education to ensure that policies, procedures, regulations and facility expectations are met. 4. Daily audit by Unit manager/designee will be conducted x1 week to ensure accuracy until 100% compliance is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 47 federal, state and other applicable laws and regulations ..." 1. Review of the third floor 300-medication cart narcotic sheet with Licensed Practical Nurse (LPN) 1 on 11/19/24 at 4:19 PM, revealed the following missing initials on the narcotic count sheet: -11/07/24 at 3:00 PM, the oncoming nurse did not initial the form. -11/07/24 at 11:00 PM, the off going nurse did not initial the form. -11/10/24 at 11:00 PM. -11/10/24 at 11:00 PM the off going nurse did not initial. -11/12/24 at 11:00 PM the off going nurse did not initial. -11/13/24 at 11:00 PM the off going nurse did not initial. -11/16/24 at 3:00 PM the oncoming nurse did not initial. -11/16/24 at 11:00 PM the oncoming nurse did not initial. -11/17/24 at 11:00 PM the on coming nurse did not initial. During an interview on 11/19/24 at 4:30 PM, LPN1 confirmed that there were missing initials on the narcotic sheet. She stated, "I am aware that we are required to initial before coming on shift and after the shift." 2. Review of the second-floor medication cart front hall narcotic sheet with Registered Nurse (RN) 1 on 11/19/24 at 4:43 PM, revealed the following missing initials on the narcotic sheet: -11/01/24 at 7:00 AM, the off going nurse did not initial. -11/07/24 at 3:00 PM, the off going nurse did not initial. -11/11/24 the oncoming and off going nurse did not initial. -11/11/24 at 11:00 PM, the off going nurse did not initial. -11/12/24 at 7:00 AM the oncoming nurse did not initial. -11/12/24 at 3:00 PM, the off going nurse did not initial. -11/16/24 at 3:00 PM, the oncoming nursing did not initial. -11/16/24 at 11:00 PM, the off going nurse did not initial.	F 755	achieved and sustained. Weekly audit x3 weeks until 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 48	F 755		

During an interview on 11/19/24 at 4:45 PM, RN1 stated, "I am aware that there needs to be sign in/sign out initial on the narcotic sheets."

During an interview on 11/19/24 at 4:47 PM, Unit Manager (UM) 1 stated, "I don't monitor the narcotic sheets as this is the nurses' responsibility, but they should be initialing when they come on and go off shift."

3. Review of the second-floor medication cart back hall narcotic sheet with RN2 on 11/19/24 at 4:52 PM, revealed the following missing initials on the narcotic sheet: -11/01/24 at 7:00 AM, the oncoming nurse did not initial. -11/01/24 at 3:00 PM, the off going nurse did not initial. -11/03/24 at 3:00 PM the oncoming nurse did not initial. -11/03/24 at 11:00 PM the off going nurse did not initial. -11/04/24 at 7:00 AM, the oncoming nurse did not initial; -11/04/24 at 3:00 PM the oncoming and off going nurses did not initial. -11/04/24 at 11:00 PM, the off going nurse did not initial. -11/06/24 at 11:00 PM, the off going nurse did not initial. -11/08/24 at 7:00 AM, the oncoming nurse did not initial. -11/08/24 at 3:00 PM, the oncoming and off going nurses did not initial. -11/08/24 at 11:00 PM, the off going nurse did not initial. -11/15/24 at 7:00 AM, the oncoming nurse did not initial. -11/15/24 at 3:00 PM, the oncoming nurse did not initial. -11/15/24 at 11:00 PM, the off going nurse did not initial. -11/16/24 at 3:00 PM, the off going nurse did not initial. -11/17/24 at 3:00 PM, the oncoming nurse did not initial. -11/17/24 at 11:00 PM, the off going nurse did not initial.

In addition, a review of the narcotic sheet, dated 11/19/24 at 11:00 PM, RN2 had pre-signed out that the narcotic sheet was accurate despite the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 49 time not being 11:00 PM but 5:01 PM. RN2 was asked why she pre-signed out the narcotic sheet. RN2 stated, "Since I am the only one who has the keys I went ahead and signed out." RN2 was asked what the standard of nursing practice dictates at the time the narcotic count was done, when you sign in/out. RN2 stated, "Well, I am aware of this, but I am the only one who has the keys." During an interview on 11/19/24 at 5:01 PM, UM1 confirmed that there were missing initials on the narcotic sheets and that no pre-initialing should be done. Review of the first-floor medication cart back hall with RN3 on 11/19/24 at 5:04 PM revealed the following initials were missing from the narcotic sheet: -11/05/24 at 7:00 AM, the oncoming nurse did not initial. -11/09/24 at 11:00 PM, the oncoming nurse did not initial. -11/10/24 at 3:00 PM, the oncoming nurse did not initial. -11/18/24 at 11:00 PM, the oncoming nurse did not initial. -11/19/24 at 7:00 AM, the off going nurse did not initial. During an interview on 11/19/24 at 5:05 PM, RN3 stated, "I am aware that initials are needed when coming on and going off. I don't know why there are blanks." Review of the first-floor mediation cart front hall with LPN3 on 11/19/24 at 5:06 PM revealed the following initials were missing from the narcotic sheet: -11/05/24 at 7:00 AM, the off going nurse did not initial. -11/05/24 at 3:00 PM, the oncoming nurse did not initial. -11/07/24 at 7:00 AM, the oncoming nurse did not initial. -11/07/24 at 11:00 PM, the off going nurse did not initial. -11/10/24 at	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ___ B. WING ___	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 50 11:00 PM, the off going nurse did not initial. -11/11/24 at 7:00 AM the oncoming nurse did not initial. -11/11/24 at 3:00 PM, the off going nurse did not initial. -11/13/24 at 3:00 PM, the oncoming nurse did not initial. -11/13/24 at 11:00 PM, the oncoming and off going nurses did not initial. During an interview on 11/19/24 at 5:06 PM, LPN3 stated, "I am aware that you should initial when coming on and going off. I don't know why there are no initials on the narcotic sheet." During an interview on 11/19/24 at 5:10 PM, UM2/RN5 stated, "As a standard of nursing practice each nurse needs to initial after the narcotic count is done." During an interview on 11/19/24 at 5:20 PM, the Director of Nursing (DON) reviewed all of the narcotic sheets and stated, "The nursing staff should be signing in/out as it's a standard of nursing practice." The DON further stated, "I was not aware of the problem. Pharmacy comes in and reminds them to sign in/out, but apparently this is a problem." During an interview on 11/22/24 at 9:48 AM, the Pharmacist stated, "I definitely look at the narcotic sheets, but have not done so for November yet, as I am here today to do the medication reviews." The Pharmacist further stated, "It has been something I have identified in the past, and when I do, I send a report to administration." The Pharmacist was asked if pre-signing out on the narcotic sheet is acceptable. She stated, "It is not acceptable practice."	F 755		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)	F 803		1/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 51 §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure menus were followed related to portion size for four of four residents (Resident (R) 76, R84, R88, and R62) who were on a mechanical soft diet and residents receiving regular texture diets of 40 sample residents. This failure had the potential to affect the residents on the dementia unit and could result in unintentional weight loss for those residents who were nutritionally at risk	F 803	F803 1. The Director of Food and Nutrition provided the correct scoop size and ordered additional scoops. The Administrator spoke with the Director of Food and Nutrition that her expectations were that the dietary staff follow the portions identified on the menu. The Dietary Staff was in-serviced by the Director of Food and Nutrition on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 52 without providing the appropriate meal portions. Findings include: Review of an undated document provided by the facility titled "Portion Control Chart" indicated the following information for scoop sizes: dark gray handle scoop capacity held one half cup; and a light gray handle scoop capacity held two thirds of a cup. 1. Review of R76's electronic medical record (EMR) titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on 03/17/22. Review of R76's EMR quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 09/25/24 indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of zero out of 15 which revealed the resident was severely cognitively impaired. Review of an untitled document provided by the facility for R76 referring to the resident's meal ticket indicated the resident was to receive "DDSI (dysphasia diet standardization initiative) Level 5: Minced and Moist" diet which indicated soft, moist, and easy to chew food items. 2. Review of R84's EMR titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on 06/29/22. Review of R84's EMR significant change "MDS" with an ARD dated 09/29/24 with a "BIMS" score of zero out of 15 which revealed the resident was severely cognitively impaired.	F 803	proper portion size. 2. The Director of Food and Nutrition reviewed resident meal tickets and observed the tray line for proper portion size and no other resident were affected. The Dietary Manager will continue with monitoring and follow up regarding adequate portions. Additional scoops, ladles and spoodles were ordered. The Dietary Staff were in-serviced on 12/16/24 by the Director of Food Nutritional services. 3. A performance action plan was developed by the Director of Food and Nutrition whereas continued monitoring weekly by the Director of Food and Nutrition would be performed for following the portion size. Any new dietary employees will also be in-serviced by the Director of Food and Nutrition on proper portion size and following the menu. 4. Daily audit by Director of Food and Nutrition/designee will monitor the tray line, will be conducted x1 week to ensure accuracy until 100% compliance is achieved and sustained. Weekly audit x3 weeks until 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 53	F 803		

Review of an untitled document provided by the facility for R84 referring to the resident's meal ticket indicated the resident was to receive "DDSI Level 5: Minced and Moist" diet.

3. Review of R88's EMR "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on 07/17/24.

Review of R88's EMR admission "MDS" with an ARD of 07/17/24 indicated the resident had a BIMS score of zero out of 15 which revealed the resident was severely cognitively impaired.

Review of an untitled document provided by the facility for R88 referring to the resident's meal ticket indicated the resident was to receive the "DDSI Level 5: Minced and Moist" diet.

4. Review of R62's EMR "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on 04/02/22.

Review of R62's EMR quarterly "MDS" with an ARD of 10/27/24 indicated the resident had a "BIMS" score of zero out of 15 which revealed the resident was severely cognitively impaired.

Review of an untitled document provided by the facility for R62 referring to the resident's meal ticket indicated the resident was to receive "DDSI Level 5: Minced and Moist" diet.

5. Review of a document provided by the facility titled, "Fall/Winter" Menu for 2024-2025 Week One lunch meal for 11/19/24 indicated the residents, who were on mechanical soft diets, were to be served one half cup of sautéed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 54 mushrooms and onions. In addition, the residents with an order for a mechanical diet were to receive polenta, half cup. During an observation of the lunch tray line and interview on 11/19/24 at 12:39 PM, Dietary Aide (DA) 2 began to serve mechanical diets for R76, R84, R88, and R62, who resided on the Dementia unit. Each resident received one half portion of the light gray handled scoop for the polenta which was placed on the plates for the four residents. In addition, DA2 used a tong to pick up the sauteed onions and mushrooms instead of half a cup as indicated on the menu. Certified Nurse Aide (CNA) 2 stated none of the four residents were on a small portion diet. In addition, DA2 served the remaining residents, using tongs to pick up the sauteed onion and mushrooms from the serving pan and placed onto the residents' plates. Review of a document provided by the facility titled, "Fall/Winter" Menu for 2024-2025 Week One dinner meal for 11/19/24 indicated the residents, who were on a regular texture diet, were to be served one- and one-half cups of ravioli. During an observation and interview on 11/19/24 at 5:08 PM, DA1 was observed standing behind the steam table located on the Dementia Unit. DA1 stated residents on the mechanical soft diet were served chopped raviolis and she used a light gray scoop to serve the residents on the mechanical soft diet. DA1 then stated the residents who were on regular texture were served from a silver serving spoon and stated she served them four raviolis.	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 55 During an interview on 11/21/24 at 11:04 AM, the Dietary Manager (DM) stated he had been in his position for the past three weeks. The DM stated the scoop sizes for the light gray handle scoop was one half cup instead of the designated portion size of two thirds per the "Portion Control Chart." The DM stated the raviolis should have been served with an eight-ounce spoodle and given two servings. The DM presented a gray handled scoop and stated it did not have one half cup identified on the scoop. During an interview on 11/21/24 at 12:49 PM, the Registered Dietician (RD) stated the portion sizes would have come from the RD. The RD stated the scoops and spoodles were to be standardized to ensure appropriate portion size. The RD stated the residents on the Dementia unit were to have their lunch meal served with a dark gray handle, instead of the light gray handled scoop since the dark gray handled scoop served one half a cup of food. The RD stated it was important to serve the residents the appropriate serving sizes to monitor the residents' intake to ensure the residents' weights remain stable. During an interview on 11/21/24 at 3:42 PM, the Director of Nursing (DON) stated she would expect the kitchen staff to ensure the correct portion size for meals to the residents and did not want to see any residents lose weight.	F 803		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		1/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 56 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure beard guards were worn during food production in accordance with professional standards for food service safety with the potential to affect 89 of 89 residents who consumed food from the kitchen. This failure had the potential for physical contamination of the food in the facility. Findings include: Review of the facility's undated policy and procedure titled, "Food Safety and Preparation," revealed "sanitary food preparation staff must wear gloves, hair net and beard net for facial hair if this applies to staff that has a beard ..." During observation of the noon meal preparation on 11/19/24 at 11:30 AM, two male kitchen staff members with beards did not have beard nets covering their beard at the food preparation station.	F 812	F812 1. The staff member(s) observed without beard guards were provided 1:1 written education in relation to this alleged deficient practice. 2. No residents were identified as having been negatively affected by similar findings. A kitchen walk-thru was conducted to ensure all bearded staff were wearing beard guards. 3. Staff educated on the requirements of F812 as it pertains to the requirement to maintain sanitary food preparation. 4. Daily audit by the Director of Food and Nutrition/designee will be conducted x1 week to ensure compliance until 100% compliance is achieved and sustained. Weekly audit x3 weeks until 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 57 During observation of the dinner meal preparation on 11/19/24 at 4:30 PM, two male kitchen staff members with beards did not have beard nets covering their beard at the food preparation station. During observation of the breakfast meal preparation on 11/20/24 at 7:45 AM, two male kitchen staff members with beards did not have beard nets covering their beard at the food preparation station. During observation of the noon meal preparation on 11/20/24 at 11:15 AM, while accompanied by the Dietary Manager (DM), two male kitchen staff members with beards did not have beard nets covering their beard at the food preparation station. During an interview on 11/20/24 at 11:20 AM, the DM stated that staff with beards must wear a beard net to cover their beard. "I did not observe the two male kitchen staff members not wearing beard nets until I observed them today." During an interview on 11/20/24 at 11:25 AM, the Dietary Aide (DA) 3 stated, "Yes, I know that I must wear a beard guard when I'm in the kitchen. I just forgot." During an interview on 11/20/24 at 11:30 AM, DA4 stated: "Yes I know that I must wear a beard guard when I'm in the kitchen. I just forgot."	F 812	and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical,	F 908		1/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	**1900 LOVERING AVENUE WILMINGTON, DE 19806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 58 and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interviews, and review of facility policy, the facility failed to ensure one of one resident's (Resident (R) 36) wheelchair was functioning properly. This had the potential for the resident to use a wheelchair that might not properly fit her body. Findings include: Review of a facility's policy titled, "Maintenance Service," dated 12/09, indicated " ... Maintenance service shall be provided to all areas of the building, grounds, and equipment ..." Review of R36's electronic medical record (EMR) "Admission Record" located under the "Profile" tab, indicated the resident was admitted to the facility on 08/10/17. During an observation on 11/19/24 at 3:46 PM, R36 was seated in a high back wheelchair. During an observation on 11/20/24 at 1:55 PM, R36 was seated in a standard wheelchair. During an observation on 11/20/24 at 5:19 PM with the Director of Rehabilitation (DOR) R36's high back wheelchair was in the resident's bathroom. The DOR stated this was the resident's original wheelchair. During an interview on 11/20/24 at 5:21 PM, Certified Nurse Aide (CNA) 2 stated R36's wheelchair was broken.	F 908	F908 1. The facility does not have the ability to retroactively address the unmet reporting of R36 broken wheelchair. 2. The facility has determined that all residents have the potential to be affected. On 11/20/24, the maintenance department removed the broken wheelchair. Director of Rehab replaced R36 high back wheelchair. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that a staff member miss reporting broke wheelchair to maintenance. The Staff Developer/designee will provide in-service education programs for reporting all defected equipment. 4. The Unit managers/designee will complete a full house wheelchair audit to identified faulty wheelchair and replace as needed. Random weekly audits of 5 wheelchairs weekly audit x3 weeks until 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING ______ B. WING ______	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 59 During an interview on 11/20/24 at 5:23 PM, the DOR stated if resident equipment was broken the staff were to contact the receptionist who in turn would report it to the Maintenance Director via TELS (an electronic web-based program to alert staff of repairs needed). During an interview on 11/20/24 at 5:27 PM, Registered Nurse (RN) 2, stated she was unaware the high back wheelchair was broken for R36. RN2 stated if she was aware she would have alerted the therapy department. During an interview on 11/20/24 at 5:34 PM, the Maintenance Director stated he had not received any reports of R36's high back wheelchair being broken through TELS. The Maintenance Director stated the CNAs could report the broken equipment to the nurse supervisor and in turn report to the receptionist who then could place a work order in the TELS system. During an interview on 11/20/24 at 5:36 PM, CNA2 stated she missed reporting the broken wheelchair to the Maintenance Director and typically did report. CNA2 revealed that the removeable arm rest on the right side of the wheelchair was broken.	F 908		