DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
Cambridge Building
263 Chapman Road Suite 200
Newark, DE 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: AL- Harmony at Kent

DATE SURVEY COMPLETED: July 8, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual and Complaint Survey was conducted at this facility from July 2, 2024 through July 8, 2024. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was sixty-nine (69). The survey sample totaled seventeen (17) residents. Abbreviations/definitions used in this state report are as follows: Contract – A legally binding written agreement between the facility and the resident which enumerates all charges for services, materials, and equipment, as well as non-financial obligations of both parties, as specified in the State regulations; CNA – Certified Nurse Assistant; ED - Executive Director; HCD - Health Care Director; LPN – Licensed Practical Nurse; MCD – Memory Care Director; MT – Medication Tech; Resident Assessment – evaluation of a resident's physical, medical, and psychosocial status as documented in a Uniform Assessment Instrument (UAI), by a Registered Nurse; RA - Resident Assistant; RN – Registered Nurse; SA (Service Agreement)– allows both parties involved (the resident and the assisted living facility) to understand the types of care and services the assisted living provides.		

Provider's Signature Tami Rice Title Executive Director Date 8/20/24

NAME OF FACILITY: AL- Harmony at Kent

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3225.5.0 **3225.5.2** **S/S - E**	These include: lodging, board, housekeeping, personal care, and supervision services; UAI (Uniform Assessment Instrument) - A document setting forth standardized criteria developed by the Division to assess each resident's functional, cognitive, physical, medical, and psychosocial needs and status. The assisted living facility shall be required to use the UAI to evaluate each resident on both an initial and ongoing basis in accordance with these regulations. **General Requirements** **All records maintained by the assisted living facility shall at all times be open to inspection and copying by the authorized representatives of the Department, as well as other agencies as required by state and federal laws and regulations. Such records shall be made available in accordance with 16 Del.C. Ch. 11, Subchapter I., Licensing by the State.** This requirement was not met as evidenced by: The facility was out of compliance with this requirement during the onsite survey. As a result, the authorized representatives of the Department never had the required access to some employee and resident records. Findings include:	**Cross reference 9.5.2, 18.2 and 18.4.**	

Provider's Signature Jamie Rice Title Executive Director Date 8/01/24

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3225.5.12 S/S - E	Cross refer 9.5.2, 18.2 and 18.4. The facility failed to provide access to: -some new hire information of employees. -training documentation of employees. -terminated employee files -some resident records that were requested to be reviewed. 7/2/24 – Per interview with E1 (ED) at approximately 10:00 AM, E1 stated the facility administrative staff all have been hired within the last 2-3 months and not all records are available to the current staff. E1 stated there was no "hand-off" of information when she was hired. 7/8/24 – Per interview with E2 (HCD) at approximately 4:00 PM, E2 confirmed not all requested resident file information was available. 7/8/24 - Findings were reviewed with E1, E2 and E3 (MCD) at the exit conference, beginning at approximately 4:10 PM. **An assisted living facility that provides direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education**	1. No Residents were negatively impacted by this deficient practice. 2. Residents do not have the potential to be negatively impacted by this deficient practice. 3. Root cause analysis revealed the requested documents need to be accessed via the Chrome system; this was not discovered until the end of survey. Additionally, the State computer system doesn't have Chrome installed on its computers. The ED will ensure access to the required records upon the first day of inspection. 4. ED will audit accessibility each day of the survey to ensure surveyor access to required documents. Audit results will be shared with the QA Committee.	Completion date 10/04/2024

Provider's Signature _____ Title _____ Date _____

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3225.8.0 3225.8.6	**programs. The mandatory training must include: communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to be taken with those persons. This paragraph shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code.** This requirement was not met as evidenced by: Based on interview, record review and review of other facility documentation, it was determined that for four (E10, E13, E14 and E15) out of six sampled employees, the facility failed to provide evidence of mandated dementia specific training. Findings include: 1. 2/9/22 – E10 (LPN) was hired. The facility had no dementia specific training in evidence. 2. 9/13/22 - E13 (CNA) was hired. The facility had no dementia specific training in evidence. 3. 1/15/24 – E14 (CNA) was hired. The facility had no dementia specific training in evidence.	1. No residents were negatively impacted by this deficient practice. E10 and E13 have completed the required Dementia training. E14 and E15 are no longer employed by the Facility. 2. All residents have the potential to be impacted. 3. Root cause analysis revealed through multiple staffing and leadership changes, the required educational trainings through Relias were not effectively monitored for compliance. Human Resources Manager will educate Managers and line-staff on the requirement of Relias course completion. Current Human Resources Manager or designee will perform weekly audits of required course completion statistics for 100% percent compliance. Those with outstanding required courses will be required to complete those trainings within 14 days; continued non-compli-	Completion date 10/4/2024

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3225.8.7 S/S - E	4. 5/8/24 – E15 (LPN) was hired. The facility had no dementia specific training in evidence. 7/2/24 – Per interview with E1 (ED) at approximately 10:00 AM, E1 stated the facility administrative staff all have been hired within the last 3-4 months and not all records are available to the current staff. E1 stated there was no "hand-off" of information when she was hired. 7/8/24 - Findings were reviewed with E1, E2(HCD) and E3 (MCD) at the exit conference, beginning at approximately 4:10 PM. **Medication Management** **Within 30 days after a resident's admission and concurrent with all UAI-based assessments, the assisted living facility shall arrange for an on-site review by an RN of the resident's medication regime if he or she self-administers medication. The purpose of the on-site review is to assess the resident's cognitive and physical ability to self-administer medication or the need for assistance with or staff administration of medication.** **The assisted living facility shall ensure that the review required by section 8.6 is documented in the resident's records, including any**	ance will result in corrective action being taken up to and including termination. New employees will begin required Relias coursework during orientation to help ensure compliance 4. The Human Resources Manager or designee will review compliance reporting weekly with the Executive Director. Department Directors will be notified of employees who have past due training modules by the Business Office Manager. 3 days will be given for the employees to complete all past due training modules. Should the employee fail to complete the outstanding training in the allotted time a corrective action will be given. The Executive Director or designee will audit the educational compliance reports weekly x 3 weeks; and monthly x 2 months until compliance is 100%. Audits results will be shared with the QA Committee.	

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3225.9.0 3225.9.5 3225.9.5.1 S/S - D	**recommendations given by the reviewer.** This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for three (R15, R16 and R17) out of three sampled resident records for self- administration of medications assessments, the facility failed to provide evidence of an on-site review by an RN of the resident's medication regime if he or she self-administers medication. Findings include: 1. 5/31/23 - R15 was admitted to the facility and currently self-administered their medications. The facility failed to provide evidence of an on-site review by an RN of the resident's medication regime. 2. 5/26/23 - R16 was admitted to the facility and currently self-administered their medications. The facility failed to provide evidence of an on-site review by an RN of the resident's medication regime. 3. 5/22/23 - R17 was admitted to the facility and currently self-administers their medication. The facility failed to provide evidence of an on-site review by an RN of the resident's medication regime.	1. No Residents were negatively impacted. 2. All Residents who self- administer medications had the potential to be negatively impacted by this deficient practice. 3. Root cause analysis revealed the Facility was without an RN for numerous months. During this time, self-administration evaluations were not completed. Healthcare Director will complete the self-administration assessments for R15, R16, and R17. Healthcare Director will assess new Resident admissions and those who have a change in condition to determine if self-administration is appropriate. Executive Director will provide education to HCD regarding regulatory requirements for Resident medication administration. 4. ED will conduct an audit following each admission and change in condition to determine compliance with the regulation. Audits will be conducted weekly x 3 weeks following admission and change in condition; monthly x 2 months until compliance is 100%. Audit findings will be shared with the QAPI committee.	Completion date 10/4/2024

Provider's Signature Jessi Fiore Title Executive Director Date 8/14/24

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3225.9.5.2 S/S - E	7/8/24 – Per interview with E2 (HCD) at approximately 4:00 PM, E2 confirmed the assessments were not in evidence. 7/8/24 - Findings were reviewed with E1 (ED), E2 and E3 (MCD) at the exit conference, beginning at approximately 4:10 PM. **Infection Control** **Requirements for tuberculosis and immunizations:** **The facility shall have on file the results of tuberculin testing performed on all newly placed residents.** This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for two (R4 and R13) out of twelve sampled resident records, tuberculin testing was not in evidence or administered at admission. Findings include: 1. 4/23/24 - R4 was admitted to the facility. The facility failed to provide tuberculin testing evidence on admission. 2. 3/30/24 - R13 was admitted to the facility. The facility failed to provide tuberculin testing evidence on admission.	1. No residents were negatively impacted by this deficient practice. R4 and R13 have been discharged from the Facility. 2. All residents have the potential to be impacted by this deficient practice. 3. Root cause analysis revealed the Facility was without an RN for numerous months. During this time, audits of Resident TB testing/availability of testing results was not completed. Healthcare Director will review new Resident admissions to ensure TB test results are present or obtained prior to admission. 4. ED or designee will conduct an audit following each admission to determine compliance with the regulation. Audits will be conducted weekly x 3 weeks following admission; monthly x 2 months until compliance is 100%. Audit findings will be shared with the QAPI committee.	Completion date 10/4/2024

Provider's Signature _____ Title _____ Date 8/26/24

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	7/8/24 – Per interview with E2 (HCD) at approximately 4:00 PM, E2 confirmed these resident's tuberculin testing was not available. 7/8/24 - Findings were reviewed with E1 (ED), E2 and E3 (MCD) at the exit conference, beginning at approximately 4:10 PM. **Minimum requirements for pre-employment require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as Quanti-FERON. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category.** This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for ten (E1, E3, E9, E10, E11, E13, E16, E17, E18 and E19) out of eleven sampled employee records, pre-hire	1. No residents were negatively impacted by this deficient practice. E9, E11, E16, E19 are no longer employed by the Facility.	

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3225.9.6 S/S - E	tuberculin testing per the State regulation was not in evidence. Findings include: 1. 5/28/24 – E1 (ED) was hired by the facility. The facility failed to provide evidence of a pre-hire tuberculin test. 2. 2/26/24 – E3 (MCD) was hired by the facility. The facility failed to provide evidence of a pre-hire tuberculin test. 3. 1/11/23 – E9 (Activities Assistant) was hired by the facility. The facility failed to provide evidence of a pre-hire tuberculin test. 4. 2/9/22 – E10 (LPN) was hired by the facility. The facility failed to provide evidence of a pre-hire tuberculin test. 5. 1/17/24 – E11 (Housekeeper) was hired by the facility. The facility failed to provide evidence of a pre-hire tuberculin test. 6. 9/13/23 – E13 (CNA) was hired by the facility. The facility failed to provide evidence of a pre-hire tuberculin test. 7. 4/3/24 - E16 (Dietary Aide) was hired by the facility. The facility failed to provide evidence of a pre-hire tuberculin test.	2. All residents have the potential to be impacted by this deficient practice. 3. Root cause analysis revealed that due to multiple staffing and leadership changes the required pre-employment tuberculin (TB) testing was not being monitored and consistently completed. E1, E3, E10, D13, E17, and E18 will complete TB testing. 4. The Business Office Manager will ensure all new hires have TB testing will be initiated prior to employee start and that TB testing is added to the new hire checklist. The Executive Director or designee will audit new employee files weekly following orientation x 3 weeks; monthly x 2 months until compliance is 100%. Audit results will be shared with the QA Committee.	Completion date 10/4/2024

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	8. 6/12/24 – E17 (RA) was hired by the facility. The facility failed to provide evidence of a pre-hire tuberculin test. 9. 8/28/23 – E18 (Marketing Director) was hired by the facility. The facility failed to provide evidence of a pre-hire tuberculin test. 10. 12/14/22 – E19 (LPN) was hired by the facility. The facility failed to provide evidence of a pre-hire tuberculin test. 7/2/24 – Per interview with E1 (ED) at approximately 10:00 AM, E1 stated the facility administrative staff all have been hired within the last 2-3 months and not all records are available to the current staff. E1 stated there was no "hand-off" of information when she was hired. 7/8/24 - Findings were reviewed with E1, E2 (HCD) and E3 (MCD) at the exit conference, beginning at approximately 4:10 PM.		
3225.9.7 S/S - E	**The assisted living facility shall have on file evidence of annual vaccination against influenza for all residents, as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against influenza must be fully informed by the facility of the health risks involved.**		

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	The reason for the refusal shall be documented in the resident's medical record. This requirement was not met as evidenced by: Based on medical record review, interview and review of facility provided documentation, it was determined that for four (R11, R15, R16 and R17) out of twelve residents sampled for an annual vaccination against influenza, the annual vaccine was not given, or the facility had no record of the vaccine being offered to the resident and declined. Findings include: 1. 8/8/23 - R11 was admitted to the facility. The facility lacked evidence that the 2023 influenza vaccine was offered or declined. 2. 5/31/23 - R15 was admitted to the facility. The facility lacked evidence that the 2023 influenza vaccine was offered or declined. 3. 5/26/23 - R16 was admitted to the facility. The facility lacked evidence that the 2023 influenza vaccine was offered or declined. 4. 5/22/23 - R17 was admitted to the facility. The facility lacked evidence that the 2023 influenza vaccine was offered or declined.	1. No residents were negatively impacted by this deficient practice. R11 has been discharged from the Facility. 2. All residents have the potential to be impacted by this deficient practice. 3. Root cause analysis revealed the Facility was without an RN for numerous months. During this time, audits of Resident annual Resident vaccine testing was not completed. Healthcare Director will review new Resident admissions to ensure annual vaccines are given or declined upon admission. R15, R16 and R17 will be offered annual vaccinations during the upcoming 2024 vaccination clinic. 4. ED or designee will conduct an audit following each admission to determine compliance with the regulation. Audits will be conducted weekly x 3 weeks following admission; monthly x 2 months until compliance is 100%, to ensure annual vaccinations have been offered/given/declined. Audit findings will be shared with the QAPI committee.	Completion date 10/04/2024

Provider's Signature _____ Title _____ Date _____

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3225.10.0 3225.10.10 S/S - E	7/8/24 – Per interview with E2 (HCD) at approximately 4:00 PM, E2 confirmed the influenza vaccine information was not available. 7/8/24 - Findings were reviewed with E1 (ED), E2 and E3 (MCD) at the exit conference, beginning at approximately 4:10 PM. **The assisted living facility shall have on file evidence of vaccination against pneumococcal pneumonia for all residents older than 65 years, or those who received the pneumococcal vaccine before they became 65 years and 5 years have elapsed, and as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against pneumococcal pneumonia must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.** This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for six (R3, R5, R7, R11, R12 and R13) out of twelve residents sampled for pneumococcal vaccines, the facility lacked evidence of the residents' pneumococcal pneumonia		

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	vaccine or a declination of such. Findings include: 1. 11/15/23 – R3 was admitted to the facility. The facility lacked evidence of the pneumonia vaccine record or that the pneumococcal pneumonia vaccine was offered or declined. 2. 3/2/24 - R5 was admitted to the facility. The facility lacked evidence of the pneumonia vaccine record or that the pneumococcal pneumonia vaccine was offered or declined. 3. 3/17/24 - R7 was admitted to the facility. The facility lacked evidence of the pneumonia vaccine record or that the pneumococcal pneumonia vaccine was offered or declined. 4. 8/8/23 - R11 was admitted to the facility. The facility lacked evidence of the pneumonia vaccine record or that the pneumococcal pneumonia vaccine was offered or declined. 5. 11/30/23 - R12 was admitted to the facility. The facility lacked evidence of the pneumonia vaccine record or that the pneumococcal pneumonia vaccine was offered or declined. 6. 4/3/24 - R13 was admitted to the facility. The facility lacked evidence of the pneumonia vaccine record or that the pneumococcal pneumonia vaccine was offered or declined.	1. No residents were negatively impacted by this deficient practice. R3, R5, and R13 h have been discharged from the Facility. 2. All residents have the potential to be impacted by this deficient practice. 3. Root cause analysis revealed the Facility was without an RN for numerous months. During this time, audits of Resident annual Resident vaccine testing was not completed. Healthcare Director will review new Resident admissions to ensure annual vaccines are given or declined upon admission. R11, R12 and R13 will be offered annual vaccinations during the upcoming 2024 vaccination clinic. 4. ED or designee will conduct an audit following each admission to determine compliance with the regulation. Audits will be conducted weekly x 3 weeks following admission; monthly x 2 months until compliance is 100%, to ensure annual vaccinations have been offered/given/declined. Audit findings will be shared with the QAPI committee.	Completion date 10/04/2024

Provider's Signature _____ Title _____ Date _____

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3225.11.0 **3225.11.2** **S/S - E**	7/8/24 – Per interview with E2 (HCD) at approximately 4:00 PM, E2 confirmed the pneumonia vaccine record information was not available. 7/8/24 - Findings were reviewed with E1 (ED), E2 and E3 (MCD) at the exit conference, beginning at approximately 4:10 PM. **Contracts** **No contract shall be signed before a full assessment of the resident has been completed and a service agreement has been executed. If a deposit is required prior to move-in, the deposit shall be fully refundable if the parties cannot agree on the services and fees upon completion of the assessment.** This requirement was not met as evidenced by: Based on record review and review of other facility documentation, it was determined that for ten (R2, R3, R4, R5, R6, R7, R11, R12, R13 and R14) out of fourteen residents sampled, the facility obtained a signed contract prior to the UAI or SA being executed or had the contract signed three days prior to resident admission. Findings include: 1. 2/29/24 - R2 was admitted to the facility. The SA was dated 4/2/24.	1. No residents were negatively impacted. R3, R4, R6, and R13 have been discharged from the Facility. 2. All residents have the potential to be negatively impacted. The records for R2, R5, R7, R11, R12 and R14 can't be changed retroactively. 3. Root cause analysis revealed the clinical and marketing leadership	

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	The initial UAI was not dated. The contract signature date was not in evidence. The Surveyor was unable to ascertain if the contract was signed prior to the UAI or SA completion. 2. 11/15/23 - R3 was admitted to the facility. The initial UAI was not in evidence. The SA was completed on 10/31/23 and the contract was signed on 10/31/23. The Surveyor was unable to ascertain if the contract was signed prior to the UAI completion. 3. 4/23/24 - R4 was admitted to the facility. The initial UAI was not dated. The first SA in evidence was dated 4/2/24. The contract was signed 4/20/24 prior to the SA execution. The Surveyor was unable to ascertain if the contract was signed prior to the UAI completion. 4. 3/2/24 - R5 was admitted to the facility. The initial UAI was completed on 1/31/24. The first SA in evidence was completed 3/26/24. The contract was signed on 1/29/24, prior to the UAI completion and the SA execution. 5. 2/29/24 - R6 was admitted to the facility. The first SA in evidence was completed 3/15/24. The contract was signed on 2/29/24, prior to the SA execution.	wasn't aware of the 3225.11.2 requirements pertaining to the timing of signatures as related to Resident admission assessments. ED will provide training to Sales/Marketing, HCD and MCD regarding 3225.11.2 compliance. 4. The ED or designee will audit new Resident admission records to ensure contracts are not signed prior to the Resident assessments. Audits to be conducted weekly x 3 weeks and monthly x 2 months until compliance is 100%. Audit results will be shared with the QA Committee.	Completion date 10/04/2024

Provider's Signature [signature] Title Executive Director Date 8/26/24

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3225.11.3 S/S - E	6. 3/17/24 - R7 was admitted to the facility. The first SA in evidence was completed 4/12/24. The contract was signed on 3/15/24, prior to the SA execution. 7. 8/8/23 - R11 was admitted to the facility. The first SA in evidence was completed on 8/8/23. The contract was signed on 8/6/23, prior to the SA execution. 8. 11/30/23 - R12 was admitted to the facility. The first SA in evidence was completed on 1/29/24. The contract was signed on 11/30/23, prior to the SA execution. 9. 4/3/24 - R13 was admitted to the facility. The contract was signed on 4/30/24, greater than 3 days after admission. 10. 5/15/24 - R14 was admitted to the facility. The initial UAI was not in evidence. The first SA in evidence was completed on 6/23/24. The contract was signed on 5/15/24, prior to the SA execution. 7/8/24 - Findings were reviewed with E1 (ED), E2 (HCD) and E3 (MCD) at the exit conference, beginning at approximately 4:10 PM. **Resident Assessment** **A resident seeking entrance shall have an initial UAI-based resident**		

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	assessment completed by a registered nurse (RN) acting on behalf of the assisted living facility no more than 30 days prior to admission. In all cases, the assessment shall be completed prior to admission. Such assessment shall be reviewed by an RN within 30 days after admission and, if appropriate, revised. If the resident requires specialized medical, therapeutic, nursing services, or assistive technology, that component of the assessment must be performed by personnel qualified in that specialty area. This requirement was not met as evidenced by:		
3225.11.5 S/S - E	Based on record review and review of other facility documentation, it was determined that for five (R2, R3, R4, R8 and R14) out of nine sampled residents for the UAI assessments, the facility failed to provide evidence that a UAI was completed within 30 days prior to admission. Findings include: 1. 2/29/24 – R2 was admitted to the facility. The initial UAI signed by E2 (HCD) was dated 2/29/24, the day of admission. 2. 11/15/23 – R3 was admitted to the facility. The initial UAI was not in evidence. 3. 4/23/24 – R4 was admitted to the facility. The initial UAI was not dated	1. No residents were negatively impacted by this deficient practice. 2. All residents have the potential to be negatively impacted by this deficient practice. Records for R2, R3, R4, R8 and R14 can't be changed retroactively. 3. Root cause analysis revealed frequent changes in leadership impacted the auditing of residents who did/did not have an initial UAI conducted prior to admission. UAI assessment will be conducted on all potential residents prior to admission and reviewed by RN HCD. 4. HCD or designee will audit Initial UAI assessments audit will be conducted weekly x 3 weeks upon notice of a pending admission and monthly x 2 months	Completion date 10/04/2024

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	as to when it was completed, so the Surveyor was unable to confirm it was done prior to admission. 4. 2/16/24 – R8 was admitted to the facility. The initial UAI was not dated as to when it was completed, so the Surveyor was unable to confirm it was done prior to admission. 5. 5/15/24 – R14 was admitted to the facility. The initial UAI was not in evidence.	until compliance is 100%. Audit results will be shared with the QA Committee.	
3225.12.0 **3225.12.1** **3225.12.1.3** **S/S - F**	7/8/24 – Per interview with E2 (HCD) at approximately 4:00 PM, E2 confirmed the initial UAIs were not available or dated as to when completed. 7/8/24 - Findings were reviewed with E1 (ED), E2 and E3 (MCD) at the exit conference, beginning at approximately 4:10 PM. **Within 30 days prior to admission, a prospective resident shall have a medical evaluation completed by a physician.** **This requirement was not met as evidenced by:** Based on record review and review of other facility documentation, it was determined that for five (R2, R5, R7, R8 and R12) out of twelve sampled residents, the facility failed to provide evidence that a Physi-,		

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3225.13.0 3225.13.1 S/S - E	cian's medical evaluation was completed within 30 days prior to admission. Findings include: 1. 2/29/24 - R2 was admitted to the facility. The Physician's medical evaluation visit was on 10/28/23, greater than 30 days prior to admission. 2. 3/2/24 - R5 was admitted to the facility. The facility failed to provide evidence of a Physician's medical evaluation completed within 30 days prior to admission. 3. 3/17/24 - R7 was admitted to the facility. The facility failed to provide evidence of a Physician's medical evaluation completed within 30 days prior to admission. 4. 2/16/24 - R8 was admitted to the facility. The Physician's medical evaluation visit was on 12/29/23, greater than 30 days prior to admission. 5. 11/30/23 - R12 was admitted to the facility. The Physician's medical evaluation visit was on 10/11/23, greater than 30 days prior to admission. 7/8/24 – Per interview with E2 (HCD) at approximately 4:00 PM, E2 confirmed the Physician's medical evaluations were not available or completed within 30-days prior to admission.	1. No Residents were negatively impacted by this deficient practice. 2. All Residents with medical evaluations greater than 30 days prior to admission have the potential to be impacted by this deficient practice. Records for R2, R5, R7 and R8 can't be changed retroactively. 3. Root cause analysis revealed through multiple changes in leadership, the 30-day requirement for pre-admission medical evaluation was not completed. Evaluations on newly admitted Residents were completed timely but without the evidence of a date on the evaluations there is no way of proving when the evaluations were completed. HCD or designee will monitor medical evaluation dates of all potential residents prior to admission to ensure compliance. 4. Healthcare Director or designee will audit Resident records weekly x3 weeks and monthly x2 until compliance is 100%, with dating medical evaluations. Audit results will be reported to QA Committee.	Completion date 10/04/2024

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	7/8/24 - Findings were reviewed with E1 (ED), E2 and E3 (MCD) at the exit conference, beginning at approximately 4:10 PM **The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.** This requirement was not met as evidenced by: Based on record review and review of other facility documentation, it was determined that for four (R3, R4, R8 and R14) out of nine sampled residents, the facility failed to provide evidence that a 30-day UAI assessment was completed. Findings include: 1. 11/15/23 – R3 was admitted to the facility. The 30-day UAI was not in evidence. 2. 4/23/24 – R4 was admitted to the facility. The 30-day UAI was not in evidence. 3. 2/16/24 – R8 was admitted to the facility. The 30-day UAI was not in evidence.	1. No Residents were negatively impacted by this deficient practice. 2. All Residents have the potential to be impacted by this deficient practice. Records for R3, R4, R8 and R14 can't be changed retroactively. 3. Root cause analysis revealed through multiple changes in leadership, the 30-day UAI requirement was overlooked. The ED will provide education to the HCD and MCD concerning the UAI requirement. The HCD will ensure the UAI is completed timely, as per regulation	Completion date 10/04/2024

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	4. 5/15/24 – R14 was admitted to the facility. The 30-day UAI was not in evidence. 7/8/24 – Per interview with E2 (HCD) at approximately 4:00 PM, E2 confirmed the 30-day UAIs were not available. 7/8/24 - Findings were reviewed with E1 (ED), E2 and E3 (MCD) at the exit conference, beginning at approximately 4:10 PM. **Services** **The assisted living facility shall ensure that:** **Food service complies with the Delaware Food Code.** **Delaware Food Code** **Delaware Food Code 3-501.12 Time/Temperature Control for Safety Food, Slacking. Frozen TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is slacked to moderate the temperature shall be held: (A) Under refrigeration that maintains the FOOD temperature at 5oC (41oF) or less; or (B) At any temperature if the FOOD remains frozen.** This requirement was not met as evidenced by:	for all Residents. HCD will audit admissions from the last 30 days to ensure UAI is completed. 4. Healthcare Director or designee will audit Resident records weekly x 3 and monthly x2 until compliance is 100%, to ensure completion of the UAI. Audit results will be reported to QA Committee.	

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3225.13.3 S/S - E	Based on observations, interview, and review of other facility documentation it was determined that the facility failed to comply with the Delaware Food Code. Findings include: 7/2/24 – 11:30 AM – During the survey of the facility, the walk-in refrigerator was unable to consistently maintain a temperature of 41 degrees Fahrenheit or below, which is required for food safety. The temperature of the walk-in refrigerator was 50 degrees F when initially tested at 11:30 AM. The refrigerator temperature had risen to 51 degrees F when tested a second time at 12:15 PM. 7/2/24 – 1:30 PM – Interview with E6 (Director of Dining) revealed that the outside latch of the fridge was not working properly resulting in the door not securely shutting when staff opened the door to access the refrigerator. During the interview, the refrigerator temperature was tested a third time and was found to be 45 degrees F. 7/2/24 - Findings were discussed with E6 (Director of Dining) at 3:10 PM and with E1 (ED) at 4:15 PM. **Service Agreements** **A service agreement based on the needs identified in the UAI shall be completed prior to or no later than**	1. There were no Residents negatively impacted by this deficient practice. 2. All Residents have the potential to be negatively impacted by this deficient practice. 3. Root cause analysis revealed a broken latch on the refrigerator unit prevented it from maintaining the appropriate temperature. There was no system in place to submit work orders; as a result, the broken latch was not repaired. 4. The broken latch was repaired during the survey. A work order system has been implemented to address physical plant issues. The ED or designee will add the work order system to the morning meeting checklist, ensuring physical plant issues are discussed and added to the work order system. The Director of Dining or designee will audit walk-in refrigerator temps daily x 3 weeks, weekly x 3 weeks and monthly x 2 months until compliance is 100%. Audit results will be reported to the QA Committee.	Completion date 10/04/2024

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	the day of admission. The resident shall participate in the development of the agreement. The resident and the facility shall sign the agreement and each shall receive a copy of the signed agreement. All persons who sign the agreement must be able to comprehend and perform their obligations under the agreement. This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for nine (R2, R5, R6, R7, R8, R11, R12, R13 and R14) out of twelve sampled residents for SA completion, the facility failed to provide evidence that the service agreement was completed within the timeframe outlined in the regulation or that the resident or family participated in the development of the agreement or was provided a copy. Findings include: 1. 2/29/24 – R2 was admitted to the facility. The first SA in evidence was completed on 4/2/24, over one month after admission. The SA was not signed by the resident/family and there was no evidence a copy was given to the resident/family. 2. 3/2/24 - R5 was admitted to the facility. The first SA in evidence was	1. No residents were negatively impacted by this deficient practice. 2. All residents have the potential to be negatively impacted by this deficient practice. Resident records for R2, R5, R6, R7, R8, R11, R12, R13, and R14 can't be changed retroactively. 3. Root cause analysis revealed turnover in leadership allowed this requirement to fall through the cracks. The HCD will ensure that upon admission all service plans are activated and signed by resident and/ or POA. Resident and/or POA will receive a copy of service agreement; this will be documented in the Resident record. 4. ED or designee will audit Resident records daily x 3 weeks, weekly x3 weeks and monthly x 2 until compliance is 100%. Audit results will be reported to the QA Committee.	Completion date 10/04/2024

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	completed on 3/26/24, approximately one month after admission. There was no evidence a copy was given to the resident/family. 3. 2/29/24 - R6 was admitted to the facility. The first SA in evidence was completed 3/15/24, approximately two weeks after admission. The SA was not signed by the resident/family and there was no evidence a copy was given to the resident/family. 4. 3/17/24 - R7 was admitted to the facility. The first SA in evidence was completed 4/12/24. The SA was not signed by the resident/family and there was no evidence a copy was given to the resident/family. 5. 2/16/24 – R8 was admitted to the facility. The SA was completed on 2/19/24, three days after admission. The SA was not signed by the resident/family and there was no evidence a copy was given to the resident/family. 6. 8/8/23 - R11 was admitted to the facility. The SA was completed on 8/8/23. The SA was not signed by the resident/family and there was no evidence a copy was given to the resident/family. 7. 11/30/23 - R12 was admitted to the facility. The first SA in evidence was completed on 1/29/24, approximately two months after admission.		

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3225.16.0 **3225.16.2 S/S - E**	There was no evidence a copy was given to the resident/family. 8. 4/3/24 - R13 was admitted to the facility. The SA was completed on 4/8/24, approximately five days after admission. There was no evidence a copy was given to the resident/family. 9. 5/15/24 - R14 was admitted to the facility. The first SA in evidence was completed on 6/23/24, over one month after admission. The SA was not signed by the resident/family and there was no evidence a copy was given to the resident/family. 7/8/24 – Per interview with E2 (HCD) at approximately 4:00 PM, E2 confirmed the SAs were not completed within the regulation timeframe or signatures in evidence. E2 stated a copy of the assessment was not given to the resident/family. 7/8/24 - Findings were reviewed with E1 (ED), E2 and E3 (MCD) at the exit conference, beginning at approximately 4:10 PM. **The resident's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number.** This requirement was not met as evidenced by:		

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	Based on record review, interview and review of other facility documentation, it was determined that for seventeen (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, and R17) out of seventeen sampled residents, the facility failed to provide evidence that the service agreement contained the resident's personal Attending Physician(s) name, address and telephone number. Findings include: 1. 7/11/22 – R1 was admitted to the facility. The service agreement completed on 6/26/24 did not contain the Attending Physician's information. 2. 2/29/24 – R2 was admitted to the facility. The service agreement completed on 4/2/24 did not contain the Attending Physician's information. 3. 11/15/23 – R3 was admitted to the facility. The service agreement completed on 3/5/24 did not contain the Attending Physician's information. 4. 4/23/24 – R4 was admitted to the facility. The service agreements completed on 4/22/24 and 5/22/24 did not contain the Attending Physician's information.	1. No residents were negatively impacted by this deficient practice. R2 is no longer in the Facility. 2. All Residents have the potential to be negatively impacted by this deficient practice. 3. Root cause analysis revealed Facility leadership was not aware of the requirement of Medical Provider name and telephone number on the Service Agreements. Medical Provider names and numbers will be added to Service Agreements for R1, R5, R6, R7, R9, R11, R12, R13, R14, R15, R16, and R17. 4. ED or designee will audit service plans for Medical Provider names and contact information weekly x 2 weeks and monthly x 2 months until compliance is 100%. Audit results will be reported to the QA Committee.	Completion date 10/04/2024

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	5. 3/2/24 - R5 was admitted to the facility. The service agreement completed on 3/26/24 did not contain the Attending Physician's information. 6. 2/29/24 – R6 was admitted to the facility. The service agreements completed on 4/15/24 and 3/15/24 did not contain the Attending Physician's information. 7. 3/17/24 – R7 was admitted to the facility. The service agreement completed on 5/16/24 did not contain the Attending Physician's information. 8. 2/16/24 – R8 was admitted to the facility. The service agreement completed on 2/19/24 did not contain the Attending Physician's information. 9. 4/11/23 – R9 was admitted to the facility. The service agreement completed on 1/5/24 did not contain the Attending Physician's information. 10. 1/16/23 – R10 was admitted to the facility. The service agreements completed on 5/16/24 and 2/7/24 did not contain the Attending Physician's information. 11. 8/8/24 – R11 was admitted to the facility. The service agreement		

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	completed on 2/5/24 did not contain the Attending Physician's information. 12. 11/30/23 – R12 was admitted to the facility. The service agreements completed on 4/18/24 and 1/29/24 did not contain the Attending Physician's information. 13. 3/30/24 – R13 was admitted to the facility. The service agreement completed on 4/8/24 did not contain the Attending Physician's information. 14. 5/15/24 – R14 was admitted to the facility. The service agreement completed on 6/23/24 did not contain the Attending Physician's information. 15. 5/31/24 – R15 was admitted to the facility. The service agreement completed on 1/26/24 did not contain the Attending Physician's information. 16. 5/24/23 – R16 was admitted to the facility. The service agreement completed on 6/19/24 did not contain the Attending Physician's information. 17. 5/22/23 - R17 was admitted to the facility. The service agreement completed on 12/11/23 did not contain the Attending Physician's information.		
3225.18.0 **3225.18.1**			

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3225.18.2 S/S - E	7/8/24 - Per interview with E1 (ED) at approximately 4:00 PM, E1 confirmed the SA forms do not contain the Physician's information. 7/8/24 - Findings were reviewed with E1, E2 (HCD) and E3 (MCD) at the exit conference, beginning at approximately 4:10 PM. **Staffing** **A staff of persons sufficient in number and adequately trained, certified or licensed to meet the requirements of the residents shall be employed and shall comply with applicable state laws and regulations.** **Delaware State Board of Nursing - RN, LPN and NA/UAP Duties 2023 ... Post Fall Assessment & Documentation - RN** This requirement was not met as evidenced by: Based on record review, interview and review of other facility and State documentation, it was determined that for six (R2, R6, R7, R10, R14 and R15) out of seventeen sampled residents, an LPN, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice, completed a resident's post fall assessment. For R2, this resulted in a delay in care. Findings include:		
3225.18.4 S/S - E			

Provider's Signature Grace Rea Title Executive Director Date 8/6/24

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	Cross refer: 16 Delaware Code, Chapter 11, Sub-chapter III 1. 2/29/24 – R2 was admitted to the facility. On 4/9/24 at approximately 3:36 PM, R2 was found kneeling on the floor by the doorway. The post fall assessment was completed by E4 (LPN), not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. On 4/9/24 at approximately 2:07 AM, R2 sustained an unwitnessed fall. Per the nursing entry into the EMR system, the post fall assessment was completed by E22 (LPN), not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. E22 noted that R2 refused to have 911 called. E2 (RN-HCD) made an entry into the EMR on 4/9/24 at 2:41 PM, that R2's "posterior head injury after the fall was assessed under 24 hours after the fall." 5/27/24 - Per State Agency reporting system and a telephone interview with F1 (son) on 7/1/24 at approximately 11:00 AM, R2 sustained a fall at approximately noon. 5/27/24 - Review of the incident report documented, the post-fall assessment was completed by E21 (LPN), not an RN as required by the	1. No residents were negatively impacted by this deficient practice. 2. All residents have the potential to be negatively impacted by this deficient practice. 3. Root cause analysis revealed leadership was not aware of the requirement for an RN to complete the post-fall assessment in the State of Delaware. All post fall assessments will be completed by the HCD. 4. The ED will review all post-fall assessments to ensure completion by an RN. Falls to be discussed during morning stand-up. An audit of post-fall assessments to be completed weekly x 3 weeks and monthly x 2 months until compliance is 100%. All audit results to be shared with the QA Committee.	Completion date 10/04/2024

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3225.19.0 **3225.19.6** **3225.19.7** **3225.19.7.2 S/S - D**	Delaware State regulation of the Board of Nursing Scope of Practice. E2 (RN-HCD) signed the incident report as reviewed but did not date or time the review. The facility failed to provide evidence of nursing notes of the fall in the EMR system between 4/23/24 and 5/31/24. E2 (RN-HCD) signed the incident report as reviewed but did not date or time the review. 2. 2/29/24 - R6 was admitted to the facility. Per EMR entry by E22 (LPN) sustained a fall on 4/25/24 at approximately 2:00 AM. The post fall assessment was completed by E22 (LPN), not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 3. 3/17/24 - R7 was admitted to the facility in the MC unit. Per EMR entry by E4 (LPN), R7 was found on the floor at approximately 3:00 PM. The post fall assessment was completed by E4 (LPN), not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 4. 1/16/23 – R10 was admitted to the facility in the MC unit. Per the EMR entry by E4 (LPN), R10 was found on the floor at approximately 9:15 AM. The post fall assessment was completed by E4 (LPN), not an RN as required by the Delaware		

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16 Delaware Code, Chapter 11, Subchapter III S/S - G	State regulation of the Board of Nursing Scope of Practice. On 5/2/24 at approximately 6:30 PM, R10 sustained a fall and was found on the floor in a fetal position. The post fall assessment was completed by E3 (LPN), not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 5. 5/15/24 – R14 was admitted to the facility in the MC unit. Per the EMR entry by E21 (LPN) on 6/2/24, R14 was found on the floor at approximately 11:30 AM. The post fall assessment was completed by E21 (LPN), not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. On 6/27/24 at approximately 6:10 PM, R14 was found on the floor by E23 (LPN). The post fall assessment was completed by E21 (LPN), not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 6. 5/31/23 – R15 was admitted to the facility. Per the EMR entry by E22 (LPN) on 2/13/24, R15 was found on the floor at approximately 1:30 PM. The post fall assessment was completed by E22 (LPN), not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice.		

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	On 6/8/24 at approximately 11:54 PM, E22 (LPN) noted in the EMR that R15 was found on the floor. The post fall assessment was completed by E22 (LPN), not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. On 7/4/24 at approximately 5:00 AM, E15 (LPN) noted R15 sustained an unwitnessed fall. The post fall assessment was completed by E15 (LPN), not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 7/8/24 - Per interview with E3 (LPN, MCD) at approximately 4:00 PM, E3 confirmed that the LPN will perform post-fall assessments. Both E2 (HCD) and E3 stated they were unaware of the Scope of Practice. 7/8/24 - Findings were reviewed with E1 (ED), E2 and E3 at the exit conference, beginning at approximately 4:10 PM. **Emergency Preparedness** **Nursing facilities shall comply with the rules and regulations adopted and enforced by the State Fire Prevention Commission or the municipality with jurisdiction.**		

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	Regular fire drills shall be held at least quarterly on each shift. Written records shall be kept of attendance at such drills. This requirement was not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to provide written records of attendance during the conducted fire drills. Findings include: The facility had evidence of a fire drill was conducted by E24 (former Director of Maintenance) on 3/19/24 at 8:00 AM on the 1st floor with both nursing staff and resident participation, however there was not a written record of who attended the drill. The facility had evidence of a fire drill was conducted by E24 (former Director of Maintenance) on 4/24/24 at 7:43 PM on the 2nd floor with both nursing staff and resident participation, however there was not a written record of who attended the drill. 7/3/24 – Per interview with E1 (ED) at approximately 11:20 AM, E1 confirmed sign in sheets for these drills was unavailable. 7/8/24 - Findings were reviewed with E1 (ED), E2 and E3 (MCD) at the	1. No residents were negatively impacted by this deficient practice. 2. All residents have the potential to be negatively impacted by this deficient practice. 3. Root cause analysis revealed due to frequent leadership changes records were not maintained. The current Executive Director will provide education to the Director of Maintenance concerning the requirements for fire drills and emergency preparedness training. The Director of Maintenance will conduct fire drills and emergency preparedness training as per regulation and document staff participation. Copies of this documentation will be kept in a binder for management access. 4. The ED will review all fire drill and emergency preparedness training documentation to ensure compliance. An audit of drill documentation to be completed monthly x 3 months until compliance is 100%. All audit results to be shared with the QA Committee.	Completion date 10/04/2024

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	exit conference, beginning at approximately 4:10 PM. **The staff on all shifts shall be trained on emergency and evacuation plans. Evacuation routes shall be posted in a conspicuous place at each nursing station.** This requirement was not met as evidenced by: Based on interview and review of other facility documentation, it was determined that four (E10, E13, E14 and E15) out of six employees' training record review, the facility failed to provide Emergency Preparedness education. Findings include: 1. 2/9/22 – E10 (LPN) was hired. The facility had no Emergency Preparedness training in evidence. 2. 9/13/22 - E13 (CNA) was hired. The facility had no Emergency Preparedness training in evidence. 3. 1/15/24 – E14 (CNA) was hired. The facility had no Emergency Preparedness training in evidence. 4. 5/8/24 – E15 (LPN) was hired. The facility had no Emergency Preparedness training in evidence. 7/2/24 - Per interview with E1 (ED) at approximately 10:00 AM, E1 confirmed that records for most employees were not accessible. E1	1. No residents were negatively impacted by this deficient practice. E14 and E15 are no longer employed by the Facility. E10 and E13 have completed emergency preparedness training. 2. All residents have the potential to be negatively impacted by this deficient practice. 3. Root cause analysis revealed due to frequent leadership changes records were not maintained. The current Executive Director will provide education to the Director of Maintenance concerning the requirements for fire drills and emergency preparedness training. The Director of Maintenance will conduct fire drills and emergency preparedness training as per regulation and document staff participation. Copies of this documentation will be kept in a binder for management access. 4. The ED will review all fire drill and emergency preparedness training documentation to ensure compliance. An audit of drill documentation to be completed monthly x 3 months until compliance is 100. All audit results to be shared with the QA Committee.	Completion date 10/04/2024

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: AL- Harmony at Kent

DATE SURVEY COMPLETED: July 8, 2024

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	stated there was no "turn-over" of information from the previous administrative staff to the current staff. The facility had evidence a disaster drill was conducted in the facility by E24 (former Director of Maintenance) on 3/19/24 at 11:00 PM on the 2nd floor and nursing staff participated, however there was not a written record of who attended the drill. 7/3/24 – Per interview with E1 (ED) at approximately 11:20 AM, E1 confirmed sign in sheets for this drill was unavailable. 7/8/24 - Findings were reviewed with E1 (ED), E2 and E3 (MCD) at the exit conference, beginning at approximately 4:10 PM. **Records and Reports** **Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.** **Reportable incidents include:** **Injury from a fall which results in transfer to an acute care facility for treatment or evaluation or which requires periodic reassessment of**		

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	the resident's clinical status by facility professional staff for up to 48 hours. This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for one (R2) out of seventeen sampled residents, the facility failed to report a fall that required periodic reassessment of the resident's clinical status. Findings include: 2/29/24 – R2 was admitted to the facility. On 4/9/24 R2 sustained an unwitnessed fall at approximately 2:07 AM. Per the EMR entry by E22 (LPN) a 1.5 cm injury to the back of the head and an abrasion to her right knee was noted. R2 refused to have 911 called. Nursing staff instituted neuro checks for R2. The facility failed to report a fall that required periodic reassessment of the R2's clinical status post fall. 7/8/24 - Per interview with E2 (HCD) at approximately 4:00 PM, E2 confirmed this fall needing periodic reassessments was not reported to the State. 7/8/24 - Findings were reviewed with E1 (ED), E2 and E3 (MCD) at the exit conference, beginning at approximately 4:10 PM.	1. No residents were negatively impacted by this deficient practice. 2. All residents have the potential to be negatively impacted by this deficient practice. 3. Root cause analysis revealed lack of education regarding the requirements for state reportable. The HCD will educate all nurses on Facility protocol for state reportable. HCD or designee will ensure all falls with injury are reported timely to the state reportable system. 4. The ED will add falls to the morning stand up meeting. ED will receive copies of all reportable incidents to ensure proper, timely state notification was made. An audit of state reportable to be conducted weekly x 3 weeks, monthly x 2 months until compliance is 100%. All audit results to be shared with the QA Committee.	Completion date 10/04/2024

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: AL- Harmony at Kent

DATE SURVEY COMPLETED: July 8, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents. (81 Del. Laws, c. 206, § 31; 83 Del. Laws, c. 22, § 1.) **12) "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect includes all of the following:** **a. Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety.** This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for one (R2) out of seventeen sampled residents, the facility failed to provide appropriate assessment of a resident after a fall which resulted in a delay in medical care. Findings include: 2/29/24 – R2 was admitted to the facility. On 4/9/24 at approximately 3:36 PM, R2 was found kneeling on the floor by the doorway. The post fall assessment was completed by E4 (LPN), not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice.		

Provider's Signature _____ Title Executive Director Date 8/15/24

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
Cambridge Building
263 Chapman Road Suite 200
Newark, DE 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: AL- Harmony at Kent

DATE SURVEY COMPLETED: July 8, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	On 4/9/24 at approximately 2:07 AM, R2 sustained an unwitnessed fall. Per the nursing entry into the EMR system, the post fall assessment was completed by E22 (LPN), not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. E22 noted that R2 refused to have 911 called. E2 (RN-HCD) made an entry into the EMR on 4/9/24 at 2:41 PM, that R2's "posterior head injury after the fall was assessed under 24 hours after the fall." 5/27/24 - Per State Agency reporting system and a telephone interview with F1 (son) on 7/1/24 at approximately 11:00 AM, R2 sustained a fall at approximately noon. 5/27/24 - Review of the incident report documented, the post-fall assessment was completed by E21 (LPN), not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. E2 (RN-HCD) signed the incident report as reviewed but did not date or time the review. The facility failed to provide evidence of nursing notes in the EMR system between 4/23/24 after a fall and 5/31/24 when the family transitioned R2 out of the facility. The Surveyor found no evidence that a Physician was notified of the 5/27/24 fall.	1. No residents were negatively impacted by this deficient practice. R2 has been discharged from the Facility. 2. All residents have the potential to be negatively impacted by this deficient practice. 3. Root cause analysis revealed leadership was not aware of the requirement for an RN to complete the post-fall assessment in the State of Delaware. All post fall assessments will be completed by the HCD. The HCD will ensure all assessments are dated and time-stamped. HCD will provide education to nursing staff on the requirements of proper EMR documentation (physician notification, signing/dating of notes and RN post-fall assessments). 4. The ED will review all post-fall assessments to ensure completion by an RN and appropriate documentation in the EMR. An audit of post-fall assessments and documentation to be completed weekly x 3 weeks and monthly x 2 months to until compliance is 100%. All audit results to be shared with the QA Committee.	Completion date 10/04/2024

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: AL- Harmony at Kent

DATE SURVEY COMPLETED: July 8, 2024

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	Per telephone interview with F1 on 7/1/24 F1 stated that R2's "behaviors changed drastically after the fall as she was no longer able to walk herself, sit up by herself, cannot stay awake, and has been very lethargic." The Surveyor was unable to verify if a change in R2's condition occurred after the fall due to the lack of data entry by staff into the facility's EMR systems. There was no evidence of a Physician's progress note regarding the fall in the chart. F1 stated he moved R2 to a facility in a closer locale on 5/31/24. F1 stated that the receiving facility's assessment resulted in a transfer to the ER. The examination and x-ray reports from that facility on 6/1/24 revealed right lateral 5th-7th rib fractures and a probable acute T12 vertebral body fracture with a 6 mm midportion. Additional L2 vertebral body compression fracture was evident but age indeterminant. The facility failed to provide appropriate assessment of a resident after a fall which resulted in a delay in medical care.		

Provider's Signature [signature] Title Executive Director Date 8/6/24

DELAWARE HEALTH AND SOCIAL SERVICES
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STATE SURVEY REPORT

NAME OF FACILITY: AL- Harmony at Kent

DATE SURVEY COMPLETED: July 8, 2024

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

Provider's Signature _____ Title _____ Date 8/21/24