

STATE SURVEY REPORT

Page 1 of 41

NAME OF FACILITY: AL- Harmony at Kent

DATE SURVEY COMPLETED: July 8, 2024

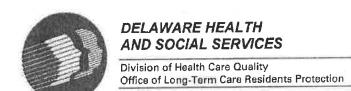
SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FO CORRECTION OF DEFICIENCE	COMPLETION DATE
	An unannounced Annual and Com-		V
	plaint Survey was conducted at this		
	facility from July 2, 2024 through		
	July 8, 2024. The deficiencies con-		
	tained in this report are based on in-		
	terview, 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 sev-		
	enteen (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	1	
	charges for services, materials, and		
	equipment, as well as non-financial		
	obligations of both parties, as speci-		
	fied in the State regulations;	1	
	CNA - Certified Nurse Assistant;		
	ED - Executive Director;	1	
	HCD - Health Care Director;		
	LPN – Licensed Practical Nurse;		
	MCD – Memory Care Director; MT – Medication Tech;	1	
	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 un-		
	derstand the types of care and ser-		
	vices the assisted living provides.		

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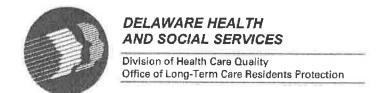
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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FO CORRECTION OF DEFICIENCE		COMPLETION DATE
3225.5.0 3225.5.2 S/S - E	These include: lodging, board, housekeeping, personal care, and supervision services; UAI (Uniform Assessment 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.			
	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.		À	
	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.	,	

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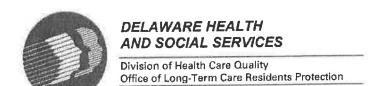
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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES		ADMINISTRATOR'S PLAN FO CORRECTION OF DEFICIENC		COMPLETION DATE
3225.5.12 5/S - E	Cross refer 9.5.2, 18.2 and 18.4. The facility failed to provide access to: -some new hire information of employeestraining documentation of employeesterminated 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	2. Reto be cient 3. Request cesse not d Addit doesn comp The Equired specti 4. ED the su required	o Residents were negatively imped by this deficient practice. esidents do not have the potential enegatively impacted by this defipractice. Dot cause analysis revealed the rested documents need to be acted via the Chrome system; this was discovered until the end of survey, ionally, the State computer system of the have Chrome installed on its nuters. ED will ensure access to the redirecords upon the first day of infon. will audit accessibility each day of arvey to ensure surveyor access to red documents. Audit results will ared with the QA Committee.	Comple	etion date 10/04/20

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programs. The mandatory trai must include: communicating persons diagnosed as having heimer's disease or other form dementia; the psychological, so and physical needs of those sons; and safety measures we need to be taken with those sons. This paragraph shall not a to persons certified to practice ricine under the Medical Practice under the Medical Practice of the programme Code.	ith lz- of ial, er- ich er- oly ed- ice		
This requirement was not met a idenced by: Based on interview, record revie and review of other facility documentation, it was determined the for four (E10, E13, E14 and E15) of six sampled employees, the faity failed to provide evidence of mandated dementia specific traing. Findings include:	pacted by this deficient practice. E10 and E13 have completed the required Dementia training. E14 and E15 are n longer employed by the Facility. 2. All residents have the potential to be impacted. 3. Root cause analysis revealed through multiple staffing and leader- ship changes, the required educations	Comp	oletion date 10/4/202
1. 2/9/22 – E10 (LPN) was hired. facility had no dementia specific training in evidence. 2. 9/13/22 - E13 (CNA) was hired.	tively monitored for compliance. Human Resources Manager will educate Managers and line-staff on the requirement of Relias course completion.		
The facility had no dementia spetraining in evidence. 3. 1/15/24 – E14 (CNA) was hire	Current Human Resources Manager o designee will perform weekly audits o required course completion statistics		
The facility had no dementia special training in evidence.	for 100% percent compliance. Those with outstanding required courses will be required to complete those training		

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within 14 days; continued non-compli-



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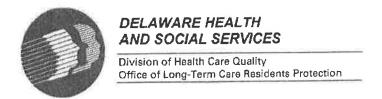
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3225.8.7 S/S - E	4. 5/8/24 – E15 (LPN) was hired. The facility had no dementia specific training in evidence. 7/2/24 – Per interview with E1 (ED) at approximately 10:00 AM, E1 stated the facility administrative staff all have been hired within the 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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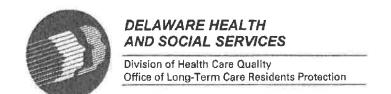
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STATEMENT OF DEFICIENCIES SECTION SPECIFIC DEFICIENCIES		ADMINISTRATOR'S PLAN FO CORRECTION OF DEFICIENCE	DR C	DATE
viewer. This requidenced is Based on and reviewer mentation for three three san self- administers administers administers the facility failed on-site redent's medicality failed to site redent's medicality failed on-site reden	record review, interview w of other facility docuni, it was determined that (R15, R16 and R17) out of impled resident records for inistration of medications ints, the facility failed to evidence of an on-site remark. The resident's in regime if he or she self-ters medication. Findings intermedications. The facility and currently self-adminitier medications. The facility and currently self-adminitier medication regime. 3 - R16 was admitted to be an admitted to a self-adminitration and admitted an	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.	Completio	on date 10/4/202

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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 ap- proximately 4:10 PM. Infection Control Requirements for tuberculosis and immunizations: The facility shall have on file the re- sults of tuberculin testing per- formed on all newly placed resi- dents. This requirement was not met as ev- idenced by: Based on record review, interview and review of other facility docu- mentation, it was determined that for two (R4 and R13) out of twelve sampled resident records, tubercu- lin 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 ad- mission. 2. 3/30/24 - R13 was admitted to the facility. The facility failed to provide tuberculin testing evidence on	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.	Complet	ion date 10/4/2024

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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

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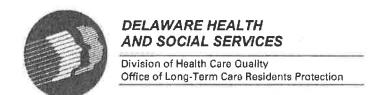
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9)	7/8/24 – Per interview with E2 (HCD) at approximately 4:00 PM, E2 confirmed these resident's tuberculin testing was not available.		
	7/8/24 - Findings were reviewed with E1 (ED), E2 and E3 (MCD) at the exit conference, beginning at approximately 4:10 PM.		
	Minimum requirements for preemployment 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 Quantiferon. 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,	No residents were negatively impacted by this deficient practice. E9, E11, E16, E19 are no longer employed by the Facility.	

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E16, E17, E18 and E19) out of eleven sampled employee records, pre-hire

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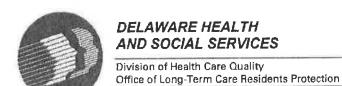
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tuberculin testing per the State regulation was not in evidence. Findings include: 1. 5/28/24 – E1 (ED) was hired by the facility. The facility failed to provide evidence of a pre-hire tuberculin test. 2. 2/26/24 – E3 (MCD) was hired by the facility. 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. 5/5 - E 2. 2/13/24 – E11 (Housekeeper) 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.	SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES		ADMINISTRATOR'S PLAN FO CORRECTION OF DEFICIENCE		COMPLETION DATE
hire tuberculin test.		ulation 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.	3. due char tube mor E1, l plet. 4. 1 ensu will and hire The audi lowin 2 mo Audi	mpacted by this deficient practice. Root cause analysis revealed that to multiple staffing and leadership nges the required pre-employment erculin (TB) testing was not being nitored and consistently completed. E3, E10, D13, E17, and E18 will come TB testing. The Business Office Manager will use all new hires have TB testing be initiated prior to employee start that TB testing is added to the new checklist. Executive Director or designee will t new employee files weekly foling orientation x 3 weeks; monthly x on this until compliance is 100%. It results will be shared with the QA	Comple	etion date 10/4/2024

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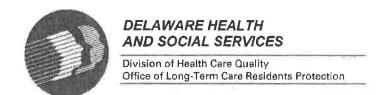
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SECTION	8. 6/12/24 – E17 (RA) was hired by the facility. The facility failed to provide evidence of a pre-hire tuberculin test. 9. 8/28/23 – E18 (Marketing Director) was hired by the facility. The facility failed to provide evidence of a pre-hire tuberculin 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.	 No residents were negatively impacted by this deficient practice. R11 has been discharged from the Facility. All residents have the potential to be impacted by this deficient practice. 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 	Compl	etion date 10/04/202
	 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. 	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.		

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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 ap- proximately 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 re- fuse to be vaccinated against pneu- mococcal 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 ev- idenced by: Based on record review, interview and review of other facility docu- mentation, it was determined that for six (R3, R5, R7, R11, R12 and R13) out of twelve residents sam- pled for pneumococcal vaccines, the facility lacked evidence of the resi- dents' pneumococcal pneumonia		

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pacted by this de R5, and R13 h ha 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. 4. ED or designed following each accompliance with the pneumococcal pneumonia vaccine was offered or declined. 5. 11/30/23 - R12 was admitted to fered/given/declined.	his deficient practice. halysis revealed the put an RN for numerous his time, audits of Resident vaccine testing ed. Healthcare Director Resident admissions to occines are given or denission. R11, R12 and ed annual vaccinations ming 2024 vaccination e will conduct an audit dmission to determine the regulation. Audits weekly x 3 weeks folimonthly x 2 months is 100%, to ensure annual shape been of hed. Audit findings will e QAPI committee.

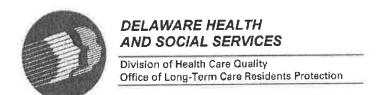
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vaccine was offered or declined.

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	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.		
	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 movein, 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:		
3225.11.0 3225.11.2 S/S - E	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:	 No residents were negatively impacted. R3, R4, R6, and R13 have been discharged from the Facility. All residents have the potential to be negatively impacted. The records for R2, R5, R7, R11, R12 and R14 can't be changed retroactively. 	
	1. 2/29/24 - R2 was admitted to the facility. The SA was dated 4/2/24.	Root cause analysis revealed the clinical and marketing leadership	

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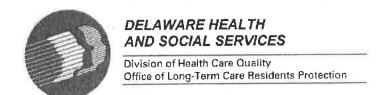
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	The initial UAI was not dated. The contract signature date was not in evidence. The Surveyor was unable to ascertain if the contract was signed prior to the UAI or SA completion.	mer ture asse Sale	n't aware of the 3225.11.2 requirents pertaining to the timing of signals as related to Resident admission essments. ED will provide training to s/Marketing, HCD and MCD regard-3225.11.2 compliance.		
	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.	Resi cont Resi duct 2 mo dit r	the ED or designee will audit new dent admission records to ensure tracts are not signed prior to the dent assessments. Audits to be conted weekly x 3 weeks and monthly x booths until compliance is 100%. Autesults will be shared with the QA mittee.	Comp	letion date 10/04/20
	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.				

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STATE SURVEY REPORT

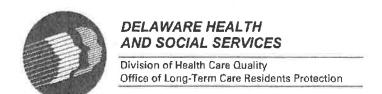
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NAME OF FACILITY: AL- Harmony at Kent

DATE SURVEY COMPLETED: July 8, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	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		
3225.11.3	was signed on 8/6/23, prior to the		
S/S - E	SA execution.	Î	
	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.		
	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.		
	l'		
	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		
	TIMES WILLIAM ALL BOOMS LANGUE.		

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DATE SURVEY COMPLETED: July 8, 2024

3225.11.5 \$/\$ - E	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.		
f.	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, 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.	 No residents were negatively impacted by this deficient practice. 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. 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. 	Completion date 10/04/20
t e	2. 11/15/23 – R3 was admitted to he facility. The initial UAI was not in evidence. 3. 4/23/24 – R4 was admitted to the	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	

Provider's Signature

facility. The initial UAI was not dated

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STATEMENT OF DEFICIENCIES

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

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ADMINISTRATOR'S PLAN FOR

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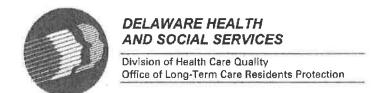
COMPLETION

NAME OF FACILITY: AL- Harmony at Kent

DATE SURVEY COMPLETED: July 8, 2024

SECTION	SPECIFIC DEFICIENCIES	CORRECTION OF DEFICIENCIES	DATE
	as to when it was completed, so the Surveyor was unable to confirm it was done prior to admission.	until compliance is 100%. Audit results will be shared with the QA Committee.	
	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.		
3225.12.0 3225.12.1	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.	A.	
3225.12.1.3 S/S - F	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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NAME OF FACILITY: AL-Harmony at Kent

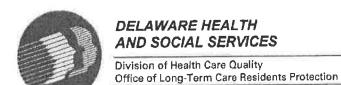
DATE SURVEY COMPLETED: July 8, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAI CORRECTION OF DEFICIE		COMPLETION DATE
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	1. No Residents were negatively in pacted by this deficient practice. 2. All Residents with medical evaluations greater than 30 days prior to a mission have the potential to be in pacted by this deficient practice. Resords for R2, R5, R7 and R8 can't changed retroactively. 3. Root cause analysis revealed throus multiple changes in leadership, the 3 day requirement for pre-admission medical evaluation was not complete Evaluations on newly admitted Research dents were completed timely but without the evidence of a date on the evaluations there is no way of proving what the evaluations were completed. HCD designee will monitor medical evaluation dates of all potential residents prito admission to ensure compliance. 4. Healthcare Director or designee was audit Resident records weekly x3 wee and monthly x2 until compliance 100%, with dating medical evaluation Audit results will be reported to Committee.	gh O- on d. si- h- u- en or a- compl or ill ks is ss.	etion date 10/04/2024

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admission.

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NAME OF FACILITY: AL- Harmony at Kent

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STATEMENT OF DEFICIENCIES SECTION SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN F CORRECTION OF DEFICIENCE	
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.	 No Residents were negatively impacted by this deficient practice. All Residents have the potential to be impacted by this deficient practice. Records for R3, R4, R8 and R14 can't be changed retroactively. 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 re- 	Completion date 10/04/20

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is completed timely, as per regulation



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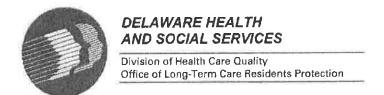
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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	4. 5/15/24 – R14 was admitted to the facility. The 30-day UAI was not in evidence. 7/8/24 – Per interview with E2 (HCD) at approximately 4:00 PM, E2	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	
	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.	monthly x2 until compliance is 100%, to ensure completion of the UAI. Audit results will be reported to QA Committee.	
	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:		

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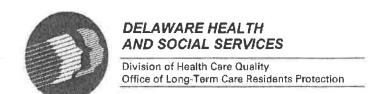
DATE SURVEY COMPLETED: July 8, 2024

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: 1. There were no Residents negatively impacted by this deficient practice. 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 approtent temperature had risen to 51 degrees Father had risen	ECTION	IT OF DEFICIENCIES ECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN F CORRECTION OF DEFICIENCE	
l O		iew of other facility docu- on it was determined that lity failed to comply with the re Food Code. Findings in 11:30 AM – During the sur- ne facility, the walk-in refrig was unable to consistently in a temperature of 41 de- internheit or below, which is d for food safety. The tem- e of the walk-in refrigerator degrees F when initially t 11:30 AM. The refrigerator degrees F when initially t 11:30 AM. The refrigerator degrees F when initially t 11:30 PM – Interview with ctor of Dining) revealed that ide latch of the fridge was king properly resulting in r not securely shutting where ened the door to access the ator. During the interview, gerator temperature was third time and was found to egrees F. Findings were discussed (Director of Dining) at 3:10 with E1 (ED) at 4:15 PM. Agreements e agreement based on the	 There were no Residents negatively impacted by this deficient practice. All Residents have the potential to be negatively impacted by this deficient practice. 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. 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 	Completion date 10/04/20

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completed prior to or no later than

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NAME OF FACILITY: AL- Harmony at Kent

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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. It is 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. No residents were pacted by this deficient shave the negatively impacted by practice. Resident record. R6, R7, R8, R11, R12, R13 be changed retroactive will ensure that upon a vice plans are activated resident and/or POA. POA will receive a copy ment; this will be doc Resident record. 1. 2/29/24 – R2 was admitted to the facility. The first SA in evidence was completed on 4/2/24, over one	ATOR'S PLAN FOR N OF DEFICIENCIES	COMPLETION DATE
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. No residents were pacted by this deficient 2. All residents have the negatively impacted by practice. Resident record. R6, R7, R8, R11, R12, R13 be changed retroactive 3. Root cause analysis ver in leadership allow ment to fall through the will ensure that upon a vice plans are activated resident and/ or POA. POA will receive a copy ment; this will be doc Resident record.		
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. 4. ED of designee will records daily x 3 we weeks and monthly x 2 is 100%. Audit results to the QA Committee.	practice. e potential to be y this deficient ords for R2, R5, 3, and R14 can't y. revealed turno- ed this require- cracks. The HCD dmission all ser- d and signed by Resident and/or of service agree- umented in the audit Resident eks, weekly x3 until compliance	etion date 10/04/202

Provider's Signature ___

facility. The first SA in evidence was

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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.	7	
	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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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

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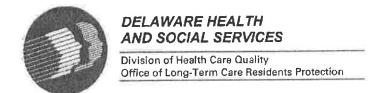
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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3225.16.0	There was no evidence a copy was		
	given to the resident/family.		
3225.16.2	8. 4/3/24 - R13 was admitted to the		
S/S - E	facility. The SA was completed on		
,	4/8/24, approximately five days af-		
	ter admission. There was no evi-		
	dence a copy was given to the resi-		
	dent/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/fam-		
	ily and there was no evidence a		
	copy was given to the resident/fam-		
		J.	
	ily.		
	7/8/24 – Per interview with E2	1	
	(HCD) at approximately 4:00 PM, E2		
	confirmed the SAs were not com-		
	pleted within the regulation		
	timeframe or signatures in evi-		
	dence. E2 stated a copy of the as-		
	sessment was not given to the resi-		
	dent/family.		
	7/8/24 Findings were reviewed		AT .
	7/8/24 - Findings were reviewed		
	with E1 (ED), E2 and E3 (MCD) at the		
	exit conference, beginning at ap-		
	proximately 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 ev-		
	idenced by:		
	idenced by:		

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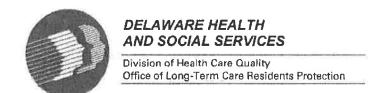
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NAME OF FACILITY: AL- Harmony at Kent

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STATEMENT OF DEFICIENCIES SECTION SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FO CORRECTION OF DEFICIENCE	
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 10/04/20

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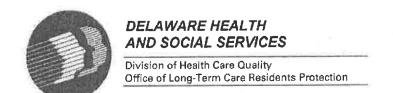
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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION
	5. 3/2/24 - R5 was admitted to the facility. The service agreement completed on 3/26/24 did not contain the Attending Physician's 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.		
M	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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S SECTION	TATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	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.		
	tain 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 con-		
3225.18.0 3225.18.1	tain 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.		- Can

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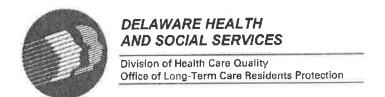
NAME OF FACILITY: AL- Harmony at Kent

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3225.18.2 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		
s	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 & Docu- mentation - 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 reg-		
225.18.4 /S - E	ulation 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:		

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DATE SURVEY COMPLETED: July 8, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES		ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES		COMPLETION
	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."	2. / neg pra 3. ship for sess by 1 4. T me Fall star me week con	No residents were negatively imported by this deficient practice. All residents have the potential to be gatively impacted by this deficient ctice. Root cause analysis revealed leaders was not aware of the requirement an RN to complete the post-fall assement in the State of Delaware. All at fall assessments will be completed the HCD. The ED will review all post-fall assessints to ensure completion by an RN. Is to be discussed during morning ind-up. An audit of post-fall assessints to be completed weekly x 3 leks and monthly x 2 months until impliance is 100%. All audit results to shared with the QA Committee.	Comp	etion date 10/04/202
	5/27/24 - Per State Agency report- ing system and a telephone inter-				

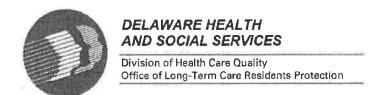
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view with F1 (son) on 7/1/24 at approximately 11:00 AM, R2 sustained

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

a fall at approximately noon.

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S SECTION	TATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION
SECTION	OF EGIT TO DET TOTERFOLD	CONNECTION OF BELLIOIEN	DAIL
	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.		
3225.19.0 3225.19.6	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		
3225.19.7 3225.19.7.7.2 S/S - D	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		
	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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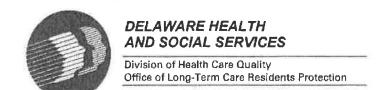
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NAME OF FACILITY: AL- Harmony at Kent

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	State regulation of the Board of Nursing Scope of Practice. On 5/2/24 at approximately 6:30		- A
	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.		
L6 Delaware Code, Chap-	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		
er 11, Sub- chapter III G/S - G	(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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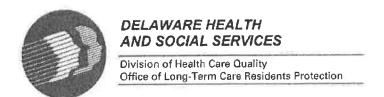
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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	On 6/8/24 at approximately 11:54 PM, E22 (LPN) noted in the EMR that R15 was found on the floor. The post fall assessment was 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.	v-	
	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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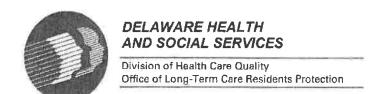
NAME OF FACILITY: AL- Harmony at Kent

DATE SURVEY COMPLETED: July 8, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCE		COMPLETION DATE
- W	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:			3100
	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:	 No residents were negatively impacted by this deficient practice. All residents have the potential to be negatively impacted by this deficient 		
	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.	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	Comple	etion date 10/04/202
	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.	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 docu-		
	7/3/24 – Per interview with E1 (ED) at approximately 11:20 AM, E1 confirmed sign in sheets for these drills was unavailable.	mentation 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.		
	7/8/24 - Findings were reviewed with E1 (ED), E2 and E3 (MCD) at the			

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN F CORRECTION OF DEFICIENCE		COMPLETION
	exit conference, beginning at approximately 4:10 PM.			
	proximately 4.10 PW.			
	The staff on all shifts shall be			
	trained on emergency and evacua-	1. No residents were negatively im-		
	tion plans. Evacuation routes shall	pacted by this deficient practice. E14		
	be posted in a conspicuous place at	and E15 are no longer employed by the		
	each nursing station.	Facility. E10 and E13 have completed		
		emergency preparedness training.	İ	
	This requirement was not met as ev-			
	idenced by:	2. All residents have the potential to be		
	Based on interview and review of	negatively impacted by this deficient practice.		
	other facility documentation, it was	practice.	1	
	determined that four (E10, E13, E14	3. Root cause analysis revealed due to		
	and E15) out of six employees' train-	frequent leadership changes records		
	ing record review, the facility failed	were not maintained. The current Exec-		
	to provide Emergency Preparedness	utive Director will provide education to		
	education. Findings include:	the Director of Maintenance concerning		
		the requirements for fire drills and		
	1. 2/9/22 – E10 (LPN) was hired. The	emergency preparedness training. The		
	facility had no Emergency Prepared-	Director of Maintenance will conduct		
	ness training in evidence.	fire drills and emergency preparedness		
	2. 9/13/22 - E13 (CNA) was hired.	training as per regulation and document staff participation. Copies of this docu-		
	The facility had no Emergency Pre-	mentation will be kept in a binder for	Comple	tion date 10/04/2024
	paredness training in evidence.	management access.	Comple	don date 10/04/2024
	pareaties training in evidence.	management access.		
	3. 1/15/24 - E14 (CNA) was hired.	4. The ED will review all fire drill and	n L	
	The facility had no Emergency Pre-	emergency preparedness training docu-		
	paredness training in evidence.	mentation to ensure compliance. An au-		
		dit of drill documentation to be com-		
	4. 5/8/24 – E15 (LPN) was hired. The	pleted monthly x 3 months until compli-		
	facility had no Emergency Prepared-	ance is 100. All audit results to be shared		

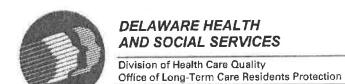
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7/2/24 - Per interview with E1 (ED) at approximately 10:00 AM, E1 confirmed that records for most employees were not accessible. E1

ness training in evidence.

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with the QA Committee.



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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
	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 2 nd 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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1152	the resident's clinical status by fa- cility 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:	No residents were negatively impacted by this deficient practice.		
	2/29/24 – R2 was admitted to the facility. On 4/9/24 R2 sustained an unwitnessed fall at approximately 2:07	2. All residents have the potential to be negatively impacted by this deficient practice.		
v	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	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.		
	periodic reassessment of the R2's clinical status post fall.	4. The ED will add falls to the morning stand up meeting. ED will receive copies	Comple	etion date 10/04/202
	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.	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		25, 2 1, 202
	7/8/24 - Findings were reviewed with E1 (ED), E2 and E3 (MCD) at the	Committee.		

Provider's Signature

exit conference, beginning at ap-

proximately 4:10 PM.

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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.		

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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.

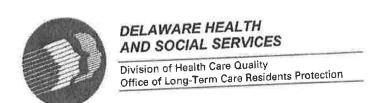
- 1. No residents were negatively impacted by this deficient practice. R2 has been discharged from the Facility.
- 2. All residents have the potential to be negatively impacted by this deficient practice.
- 3. Root cause analysis revealed leadership was not aware of the requirement for an RN to complete 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

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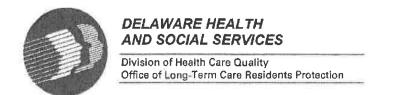
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	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	CORRECTION OF DEFICIENCIES	DAIL	
ECTION	SPECIFIC DEL TOLETO.			
	Per telephone interview with F1 on 7/1/24 F1 stated that R2's "behaviors changed drastically after the fall as she was no longer able 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 June Fie

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