DELAWARE HEALTH AND SOCIAL SERVICES

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

DHSS - DHCQ
263 Chapman Road, Suite 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: AL- Harmony at Kent

DATE SURVEY COMPLETED: May 21, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Annual and Complaint Survey was conducted at this facility from May 19, 2025, through May 21, 2025. 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 eighty-one (81). The survey sample totaled ten (10) residents plus two (2) additional subsampled residents. Abbreviations/definitions used in this state report are as follows: CNA – Certified Nurse Assistant; ED - Executive Director; HCD - Health Care Director; LPN – Licensed Practical Nurse; MCD – Memory Care Director; MD – Maintenance 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 – room air; RA - Resident Assistant; RDO – Regional Director of Operations; RDRC – Regional Director of Resident Care; RHR – Regional Human Resources; 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. These include: lodging, board, housekeeping, personal care, and supervision services; SD – Sales Director;		

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	SVP – Senior Vice President of Operations; 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.		
3225.0	**General Requirements**		
3225.5.12 S/S- D	**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 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 two (E19 and E22) out of five sampled employees, the facility failed to	3225.5.12 A. E19 remains employed in community. Community was not able to locate documentation dementia education was completed. E22 remains employed in community. Community was not able to locate documentation dementia education was completed. B. All residents have the potential to be affected by this deficient practice. C. A root cause analysis revealed the required education trainings for "Dementia" was not being properly monitored for compliance due to leadership turnover. An education audit for all current staff was completed on 6/9/25 and all staff will complete "Dementia" training by 7/05/2025. D. The ED/designee will conduct a weekly audit for all staff, including new hires, for x4 weeks, until 100% compliance is verified then monthly x2 until 100% verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation.	7/05/2025

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	provide evidence of the mandated annual dementia specific training. Findings include: 1. 9/13/23 – E19 (MC-CNA) was hired. The facility had no dementia specific training in evidence. 2. 10/18/23 – E22 (MC-CNA) was hired. The facility had no dementia specific training in evidence. 5/20/25 - Per interview with E9 (BD) at approximately 11:00 AM, E9 confirmed the above trainings were not in evidence. 5/21/25 - Findings were reviewed with E1 (ED), E2(HCD), E10 (RDRC), E11 (RDO), E12 (RHR) and E13 (SVP) at the exit conference, beginning at approximately 3:30 PM.		
3225.9.0 **3225.9.5** **3225.9.5.2** **S/S – E**	**Infection Control** **Requirements for tuberculosis and immunizations:** **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 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,**	3225.9.5 A. E7 remains employed in community. Community was not able to locate documentation pre-hire TB was administered. E8 remains employed in community. Community was not able to locate documentation pre-hire TB was administered. E14 remains employed in community. Community was not able to locate documentation pre-hire TB was administered. E15 is no longer employed with community. Community was not able to locate documentation pre-hire TB was administered. E16 remains employed in community. Community was not able to locate documentation pre-hire TB was administered. E17 is no longer employed with community. Community was not able to locate documentation pre-hire TB was administered.	7/05/25

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	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 six (E7, E8, E14, E15, E16 and E17) out of seven sampled employee records, pre-hire tuberculin testing per the State regulation was not in evidence. Findings include: 1. 1/7/25 – E7 (MD) was hired. The facility failed to provide evidence of a pre-hire tuberculin test. 2. 2/10/25 – E8 (AD) was hired by the facility. The facility failed to provide evidence of a pre-hire tuberculin test. 3. 4/16/25 – E14 (DA) was hired by the facility. The facility failed to provide evidence of a pre-hire tuberculin test. 4. 2/26/25 – E15 (RA) was hired by the facility. The facility failed to provide evidence of a pre-hire tuberculin test. 5. 12/18/24 – E16 (RA) was hired by the facility. The facility failed to provide evidence of a pre-hire tuberculin test. 6. 12/18/24 – E17 (Cook) was hired by the facility. The facility failed to provide evidence of a pre-hire tuberculin test.	B. All residents have the potential to be affected by this deficient practice. An audit of new hires from 1/1/25 to present was started on 6/11/25 to ensure required records are available. C. Root cause analysis revealed the need for improvement to hiring processes that ensures the community meets the regulations for the State of Delaware. Due to leadership turnover, the required pre-employment tuberculin (TB) testing was not being monitored for compliance. The Business Office Manager will ensure all new hires receive their TB testing as part of the onboarding process, prior to orientation. D. The ED/designee will conduct a weekly audit for all new hires for x4 weeks, until 100% compliance is verified then monthly x2 until 100% verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation.	

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	5/21/25 – Per interview with E9 (BD) at approximately 11:00 AM, E9 confirmed the pre-hire testing was not in evidence. 5/21/25 - Per interview with E1 (ED) at approximately 3:00 PM, E1 confirmed the pre-hire testing was not in evidence. 5/21/25 - Findings were reviewed with E1, E2(HCD), E10 (RDRC), E11 (RDO), E12 (RHR) and E13 (SVP) at the exit conference, beginning at approximately 3:30 PM.		
3225.9.6 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. The reason for the refusal shall be documented in the resident's.** 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 (R1, R6, R9 and R10) out of ten residents sampled for an annual vaccination against influenza, the annual vaccine was not given, or the facility lacked evidence of the vaccine being offered to the resident and declined. Findings include:	3225.9.6 A. R1 no longer resides in the community, has since expired. Community was not able to locate documentation influenza was offered or declined. R6 continues to reside in the community. Community was not able to locate documentation influenza was offered or declined. R9 continues to reside in the community. Community was not able to locate documentation influenza was offered or declined. R10 continues to reside in the community. Community was not able to locate documentation influenza was offered or declined. B. Newly admitted and current residents have the potential to be affected by this deficient practice. An audit of current residents was started on 5/22/25 to verify vaccination or vaccination declination is documented for all current residents to ensure all required records are available.	7/05/2025

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	1. 8/31/23 - R1 was admitted to the facility. The facility lacked evidence that the 2024 influenza vaccine was offered or declined. 2. 6/30/23 – R6 was admitted to the facility. The facility lacked evidence that the 2024 influenza vaccine was offered or declined. 3. 2/9/24 – R9 was admitted to the facility. The facility lacked evidence that the 2024 influenza vaccine was offered or declined. 4. 7/2/22- R10 was admitted to the facility. The facility lacked evidence that the 2024 influenza vaccine was offered or declined. 5/21/25 – Per interview with E2 (HCD) at approximately 3:00 PM, E2 confirmed the above influenza vaccine information was not in evidence. 5/21/25 - Findings were reviewed with E1 (ED), E2, E10 (RDRC), E11 (RDO), E12 (RHR) and E13 (SVP) at the exit conference, beginning at approximately 3:30 PM.	C. Root cause analysis revealed the need for administrative re-education on facility processes regarding vaccination regulations for the State of Delaware. This training was started by ED/HCD on 6/9/25 and is ongoing, to be completed by 6/30/25. The Community will review and revise new admission paperwork to ensure requirement is met. D. The HCD/designee will conduct a weekly audit for all new admissions for x4 weeks, until 100% compliance is verified then monthly x2 until 100% verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation.	
3225.9.7 **S/S -E**	**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.**	3225.9.7. A. R1 no longer resides in the community, has since expired. Community was not able to locate documentation pneumococcal vaccine was offered or declined. R2 no longer resides in the community. Community was not able to locate documentation pneumococcal vaccine was offered or declined. R3 continues to reside in the community. Community was not able to locate documentation pneumococcal vaccine was offered or declined. R6 continues to reside in the community. Community was not able to locate documentation pneumococcal vaccine was offered or declined.	7/05/2025

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	"Pneumococcal Vaccine Timing for Adults- Adults >/= 65 years old Complete pneumococcal vaccine schedules... PCV13 only at any age- Option A: >/= 1 year, give PVC20, Option B: >/= 1 year, give PPSV23." U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for seven (R1, R2, R3, R6, R7, R9 and R10) out of ten residents sampled for pneumococcal vaccines, the facility lacked evidence of the residents' pneumococcal pneumonia vaccine, the updated vaccine per CDC guidelines or that the vaccine was offered and declined. Findings include: 1. 8/31/23 – R1 now aged 87, was admitted to the facility. R1 received the PPSV23 pneumococcal vaccine on 10/12/18. The facility was unable to provide any documentation of R1 completing the pneumococcal vaccine schedule by receiving a PVC20 vaccine or that it was offered and declined. 2. 11/3/24 – R2 was admitted to the facility. R2 received the PPSV23 pneumococcal vaccine on 3/10/15. The facility was unable to provide any documentation of R2 completing the pneumococcal vaccine schedule by receiving a PVC20 vaccine or that it was offered and declined.	R7 continues to reside in the community. Community was not able to locate documentation pneumococcal vaccine was offered or declined. R9 continues to reside in the community. Community was not able to locate documentation pneumococcal vaccine was offered or declined. R10 continues to reside in the community. Community was not able to locate documentation pneumococcal vaccine was offered or declined. B. Newly admitted and current residents have the potential to be affected by this deficient practice. An audit of current residents was started on 5/22/25 to verify vaccination or vaccination declination is documented for all current residents to ensure all required records are available. C. Root cause analysis revealed the need for administrative re-education on facility processes regarding vaccination regulations for the State of Delaware. This training was started by ED/HCD on 6/9/25 and is ongoing, to be completed by 6/30/25. The Community will review and revise new admission paperwork to ensure requirement is met. D. The HCD/designee will conduct a weekly audit for all new admissions for x4 weeks, until 100% compliance is verified then monthly x2 until 100% verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation.	

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	3. 3/25/25 – 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. 4. 6/30/23 – R6 was admitted to the facility. R6 received the PPSV13 pneumococcal vaccine on 5/4/15. The facility was unable to provide any documentation of R6 completing the pneumococcal vaccine schedule by receiving a PVC20 vaccine or that it was offered and declined. 5. 8/14/23 - R7 was admitted to the facility. R7 received the PPSV23 on 11/16/12 and the PPSV13 pneumococcal vaccine on 5/10/22. The facility was unable to provide any documentation of R7 completing the pneumococcal vaccine schedule by receiving a PVC20 vaccine or that it was offered and declined. 6. 2/9/24 – R9 was admitted to the facility. The facility lacked evidence of the pneumonia vaccine record or that the pneumococcal pneumonia vaccine was offered or declined. 7. 4/3/24 - R10 was admitted to the facility. The facility lacked evidence of the pneumonia vaccine record or that the pneumococcal pneumonia vaccine was offered or declined. 5/21/25 – Per interview with E2 (HCD) at approximately 3:00 PM, E2 confirmed the above pneumococcal pneumonia vaccine information was in evidence. 5/21/25 - Findings were reviewed with E1 (ED), E2, E10 (RDRC), E11 (RDO), E12 (RHR) and E13 (SVP) at the exit conference, beginning at approximately 3:30 PM.		

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3225.11.0 **3225.11.2** **S/S -D**	**Resident Assessment** **A resident seeking entrance shall have an initial UAI-based resident assessment completed by a registered nurse (RN) acting on behalf of the assisted living facility no more than 30 days prior to admission. In all cases, the assessment shall be completed prior to admission. Such assessment shall be reviewed by an RN within 30 days after admission and, if appropriate, revised. If the resident requires specialized medical, therapeutic, nursing services, or assistive technology, that component of the assessment must be performed by personnel qualified in that specialty area.** This requirement was not met as evidenced by: Based on interview, record review and review of other facility documentation, it was determined that for one (R3) out of ten 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: 3/25/25 – R3 was admitted to the facility. The initial UAI was not in evidence. 5/21/25 – Per interview with E2 (HCD) at approximately 3:00 PM, E2 confirmed the initial UAI assessment was not in evidence. 5/21/25 - Findings were reviewed with E1 (ED), E2, E10 (RDRC), E11 (RDO), E12 (RHR) and E13 (SVP) at the exit conference, beginning at approximately 3:30 PM.	3225.11.2 A. R3 continues to reside in the community. Community was not able to locate the initial UAI assessment. R3 will have current UAI in place as of 6/30/25. B. Newly admitted residents have the potential to be affected by this deficient practice. C. A root cause analysis revealed the need for administration re-education on facility processes for "Assessment Requirements". This training was started by ED/HCD on 6/9/25 and is ongoing, to be completed by 6/30/25. D. The HCD/designee will conduct a weekly audit for all new admissions for x4 weeks, until 100% compliance is verified then monthly x2 until 100% verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation.	7/05/2025

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3225.11.5 **S/S -D**	**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 two (R3 and R7) out of ten sampled residents, the facility failed to provide evidence that a 30-day or annual UAI assessment was completed. Findings include: 1. 3/25/25 – R3 was admitted to the facility. The 30-day UAI was not in evidence. 2. 8/14/23 – R7 was admitted to the facility. The annual UAI due in January 2025 was not in evidence. 5/21/25 – Per interview with E2 (HCD) at approximately 3:00 PM, E2 confirmed the above UAI assessments were not in evidence. 5/21/25 - Findings were reviewed with E1 (ED), E2, E10 (RDRC), E11 (RDO), E12 (RHR) and E13 (SVP) at the exit conference, beginning at approximately 3:30 PM.	3225.11.5 A. R3 continues to reside in the community. Community was not able to locate the 30-Day UAI assessment. R3 will receive a 30-Day assessment by 7/30/25. R7 continues to reside in the community. Community was not able to locate the annual UAI assessment. R7 will receive an annual assessment by 6/30/25. B. Newly admitted residents and current residents have the potential to be affected by this deficient practice. C. A root cause analysis revealed the need for administration re-education on facility processes for "Assessment Requirements". This training was started by ED/HCD on 6/9/25 and is ongoing, to be completed by 6/30/25. D. The HCD/designee will conduct a weekly audit for all new admissions for x4 weeks, until 100% compliance is verified then monthly x2 until 100% verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation	7/05/2025
3225.13.0 **3225.13.1** **S/S – E**	**Service Agreements** **A service agreement based on the needs identified in the UAI shall be completed prior to or no later than 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**	3225.13.1 A. R3 continues to reside in the community. Community was not able to locate the signed service plan. A current and signed service plan will be in place by 6/30/25.	7/05/2025

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	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 five (R3, R5, R7, R9 and R10) out of ten sampled residents, the facility failed to provide evidence that the service agreement had been signed or that a copy was given to the resident when completed. Findings include: 1. 3/25/25 – R3 was admitted to the facility. There facility lacked evidence that a service agreement was completed. 2. 6/30/22 – R5 was admitted to the facility. R5's service agreement was completed on 4/9/25. The facility lacked evidence that the SA was signed by the resident or that a copy was given to R5. 3. 8/14/23 – R7 was admitted to the facility. R7's service agreement was completed on 1/11/25. The facility lacked evidence that the SA was signed by the resident or that a copy was given to R7. 4. 2/9/24 – R9 was admitted to the facility. R9's service agreement was completed on 2/4/25. The facility lacked evidence that the SA was signed by the resident or that a copy was given to R9. 5. 7/1/22 – R10 was admitted to the facility. R10's service agreement was completed on 2/4/25. The facility lacked evidence that the	R5 continues to reside in the community. Community was not able to locate the signed service plan. A current and signed service plan will be in place by 6/30/25. R7 continues to reside in the community. Community was not able to locate the signed service plan. A current and signed service plan will be in place by 6/30/25. R9 continues to reside in the community. Community was not able to locate the signed service plan. A current and signed service plan will be in place by 6/30/25. R10 continues to reside in the community. Community was not able to locate the signed service plan. A current and signed service plan will be in place by 6/30/25. B. Newly admitted residents and current residents have the potential to be affected by this deficient practice. C. A root cause analysis revealed the need for administration re-education on facility processes, "Service Agreements". This training was started by ED/HCD on 6/9/25 and is ongoing, to be completed by 6/30/25. D. The HCD/designee will conduct a weekly audit for all new admissions for x4 weeks, until 100% compliance is verified then monthly x2 until 100% verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation	

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	SA was signed by the resident or that a copy was given to R10. 5/21/25 – Per interview with E2 (HCD) at approximately 3:00 PM, E2 confirmed the above SA assessments were not signed by the resident or the resident representative, and there was no evidence a copy of the SA had been provided. 5/21/25 - Findings were reviewed with E1 (ED), E2, E10 (RDRC), E11 (RDO), E12 (RHR) and E13 (SVP) at the exit conference, beginning at approximately 3:30 PM.		
3225.13.3 S/S – E	**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: Based on record review, interview and review of other facility documentation, it was determined that for eight (R1, R2, R4, R5, R6, R7, R9 and R10) out of ten 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. 8/31/23 – R1 was admitted to the facility. The service agreement completed on 1/2/25 did not contain the Attending Physician's information. 2. 11/3/24 – R2 was admitted to the facility. The service agreement completed on	3225.13.3 A. R1 no longer resides in the community, has since expired. Community was not able to provide service plan that had attending physician listed. R2 no longer resides in the community. Community was not able to provide service plan that had attending physician listed. R4 continues to reside in the community. Community was not able to provide service plan that had attending physician listed. R4 service plan has been updated to include attending physician information. R5 continues to reside in the community. Community was not able to provide service plan that had attending physician listed. R5 service plan has been updated to include attending physician information. R6 continues to reside in the community. Community was not able to provide service plan that had attending physician listed. R6 service plan has been updated to include attending physician information.	7/05/2025

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	12/4/24 did not contain the Attending Physician's information. 3. 4/23/24 – R4 was admitted to the facility. The service agreement completed on 4/23/25 did not contain the Attending Physician's information. 4. 6/30/22 - R5 was admitted to the facility. The service agreement completed on 4/9/25 did not contain the Attending Physician's information. 5. 6/30/23 – R6 was admitted to the facility. The service agreement completed on 1/20/25 did not contain the Attending Physician's information. 6. 8/14/23 – R7 was admitted to the facility. The service agreement completed on 1/11/25 did not contain the Attending Physician's information. 7. 2/9/24 – R9 was admitted to the facility. The service agreement completed on 2/4/25 did not contain the Attending Physician's information. 8. 7/1/22 – R10 was admitted to the facility. The service agreement completed on 2/4/25 did not contain the Attending Physician's information. 5/21/25 – Per interview with E2 (HCD) at approximately 3:00 PM, E2 confirmed the service agreements do not contain the physician's information. 5/21/25 - Findings were reviewed with E1 (ED), E2, E10 (RDRC), E11 (RDO), E12 (RHR) and E13 (SVP) at the exit conference, beginning at approximately 3:30 PM.	R10 continues to reside in the community. Community was not able to provide service plan that had attending physician listed. R10 service plan has been updated to include attending physician information. B. Newly admitted residents and current residents have the potential to be affected by this deficient practice. C. A root cause analysis revealed the need for additional IT support for current EMR system to ensure attending physician information will be transferred to the resident service plan upon execution. In the interim to satisfy the requirement, attending physician information will be written on the service plan for all current residents. A service plan audit was started on 6/10/25, and is ongoing, to be completed by 6/30/25. D. The HCD/designee will conduct a weekly audit for all new admissions for x4 weeks, until 100% compliance is verified then monthly x2 until 100% verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation.	

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3225.14.0 **3225.14.1** **S/S – E** **Del.C. Ch 11, Subchapter II - § 1121. Resident's rights.** **§ 1123. Notice to patient.**	**Resident Rights** **Assisted living facilities are required by 16 Del.C. Ch. 11, Subchapter II, to comply with the provisions of the Rights of Patients covered therein.** **(b) Copies of § 1121 of this title shall be furnished to the resident upon admittance to the facility; all residents currently residing in the facility; and the authorized representative under § 1122 of this title. The long-term care facility shall retain in its files a statement signed by each person listed in this subsection that the person has received a copy of § 1122 of this title.** This requirement was not met as evidenced by: Based on record review and interview, it was determined for seven (R1, R5, R6, R7, R8, R9 and R10) out of ten residents reviewed for updated resident rights notification, the facility failed to ensure that the resident or resident representative was notified and signed off on the updated resident rights form. Findings include: The Resident Rights form (updated September 2023) required each resident or resident representative to sign and date acknowledging the receipt of a copy of the updated Resident Rights. 1. 8/31/23 – R1 was admitted to the facility. The facility was unable to provide any documentation of R1 or R1's resident representative being notified and signing off on the updated Resident Rights form.	3225.14.0 A. R1 no longer resides in the community, has since expired. Community was not able to provide a signed updated Resident Rights document. R5 continues to reside at the community. Community was not able to provide a signed updated Resident Rights document. R6 continues to reside at the community. Community was not able to provide a signed updated Resident Rights document. R7 continues to reside at the community. Community was not able to provide a signed updated Resident Rights document. R8 continues to reside at the community. Community was not able to provide a signed updated Resident Rights document. R9 continues to reside at the community. Community was not able to provide a signed updated Resident Rights document. R10 continues to reside at the community. Community was not able to provide a signed updated Resident Rights document. B. Newly admitted residents and current residents have the potential to be affected by this deficient practice. C. A root cause analysis revealed the need for administration to update company documents to the most current version of the Resident Rights document. This was corrected on 5/21/25. Current residents will receive the correct version to review and sign by 7/05/25. D. The ED/designee will conduct a weekly audit for all new admissions for x4 weeks, until 100% compliance is verified then monthly x2 until 100% verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation.	7/05/2025

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	2. 6/30/22 – R5 was admitted to the facility. The facility was unable to provide any documentation of R5 or R5's resident representative being notified and signing off on the updated Resident Rights form. 3. 6/30/23 – R6 was admitted to the facility. The facility was unable to provide any documentation of R6 or R6's resident representative being notified and signing off on the updated Resident Rights form. 4. 8/14/23 – R7 was admitted to the facility. The facility was unable to provide any documentation of R7 or R7's resident representative being notified and signing off on the updated Resident Rights form. 5. 5/26/23 – R8 was admitted to the facility. The facility was unable to provide any documentation of R8 or R8's resident representative being notified and signing off on the updated Resident Rights form. 6. 2/9/24 – R9 was admitted to the facility. The facility was unable to provide any documentation of R9 or R9's resident representative being notified and signing off on the updated Resident Rights form. 7. 7/1/22 – R10 was admitted to the facility. The facility was unable to provide any documentation of R10 or R10's resident representative being notified and signing off on the updated Resident Rights form. 5/21/25 – Per interview with E23 (SD) at approximately 2:00 PM, E23 confirmed the current facility contract contains the updated rights, and the resident or resident repre-		

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	sentative acknowledges the receipt of the information. E23 stated the resident rights poster is on display in the facility. 5/21/25 – Per interview with E1 (ED) at approximately 3:00 PM, E1 stated there is no evidence the updated resident rights had been distributed with a signed acknowledgement to the currently housed residents. 5/21/25 - Findings were reviewed with E1, E2(HCD), E10 (RDRC), E11 (RDO), E12 (RHR) and E13 (SVP) at the exit conference, beginning at approximately 3:30 PM.		
3225.16.0 3225.16.2 S/S- E	**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 four (R1, R6, , R6, R7 and R10) out of twelve residents reviewed for Accidents, the facility failed to ensure that nursing services met professional standards as evidenced by having LPNs complete the post fall assessment and documentation for residents' post fall which violates the Delaware State Board of Nursing Scope of Practice. Findings include:	3225.16.2 A. No residents were negatively impacted by this practice. R1 no longer resides in the community, has since expired. R6 continues to reside at the community. R7 continues to reside at the community. R10 continues to reside at the community. B. All residents have the potential to be affected by this deficient practice. C. A root cause analysis revealed the need for additional re-education for LPN staff to ensure they understand fall assessment requirements. This training was started by HCD on 6/13/25 and is ongoing, to be completed by 6/30/25. All after hour post-fall assessments with be conducted by HCD/RN designee via telehealth on a company issued device.	7/05/2025

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	1. 8/31/23 – R1 was admitted to the facility. 1/19/25 - Per EMR entry at 12:41 AM, E24 (LPN) wrote [sic] "Incident Writer called into resident room by aid stating resident is on the floor. Upon arrival resident laying on abdomen, head facing closet door, feet underneath bed, wheelchair next to dresser, bed raised. VS 115/75, T97.3, P67, R20, o2 sat 97% on room air. Resident asked what happed, resident unable to state what occurred due to dementia. AOx1, speech clear. 2 persons assist. c/o pain when assisted back to bed, could not bear weight. No bumps, abrasion scrapes to body or head. Team health /POA son/MOD notified. Voicemail left for son. pending return call. Resident changed, call bell in reach, bed to lowest position, all safety measures maintained". The post fall assessment was completed by E24, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 2. 6/30/23 – R6 was admitted to the facility. 1/21/25 - Per EMR entry at 10:40 PM, E25 (LPN) wrote [sic] "CNA calls to this writer the resident is on the floor. Arrive to room H133 to find Resident laying on the floor near the bathroom and apt door. Asked the Resident what happened. Resident states he does not know what happened. Asked Resident if anything is hurting. Resident states nothing is hurting. ROM is baseline. B/P 129/58, HR 74, RR 18, T 97.4 and Spo2 92% on ra. Resident got self to seated position but could ONLY skoot across the floor. Resident is redirected. Staff x3 assisted Resident to W/C. Resident is thankful to staff. No bruising or open areas	D. The ED/designee will conduct a weekly audit for all post-fall assessments for x4 weeks, until 100% compliance is verified then monthly x2 until 100% verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation.	

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	observed at this time. Resident is incontinent of urine and is cleaned up. Resident is wearing white socks. Non-slip socks are placed on feet at this time. POA,Wife/Team Health/ADON notified". The post fall assessment was completed by E24, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 3/5/25 – Per EMR entry at 4:34 PM, E4 (LPN) wrote [sic] "This writer was notified by staff that resident was on the floor and staff assisted resident off the floor and assisted to wheelchair. Upon arrival resident noted sitting in wheelchair, resident asked what occurred resident stated, "I was getting in chair", pointing at one of the chairs located in the sitting area. Resident denied hitting head and denied pain or discomfort. No injuries noted at time of assessment. +ROM to all extremities. Resident notified to asked staff for assistance when transferring. POA/MD/Oncoming Staff notified. VS: 117/68 74 19 98.0 95%RA". The post fall assessment was completed by E4, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 3/22/25 – Per EMR entry at 11:30 PM, E25 (LPN) wrote [sic]" CNA reports to this writer. Resident is found on the floor next to his bed approx. 2015. Resident presents with an 2cmx2cm abrasion to the top of his Left hand. Resident refused vital signs but states he did not hit head. ROM WNL. Resident is assisted to bed x3 persons. First aid and band aid applied to Left hand. Resident is incontinent of		

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	urine at this time and is cleaned up. POA/Team Health/On coming staff notified. Message left to POA. Awaiting call back". The post fall assessment was completed by E25, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 3/24/25 – Per EMR entry at 5:23 AM, E4 (LPN) wrote [sic]" This writer alerted by staff that resident had a fall in main area of unit. Upon arrival resident noted sitting on buttocks with knees bent and arms at side. Staff stated resident was attempting to get up out of wheelchair to transfer to chair at table. Staff stated resident fell to floor on left side. Staff stated resident did not hit head. No complaints of pain or discomfort voiced at time of fall. +ROM to all extremities. No post fall injuries noted due to this fall. Resident assisted to feet by 3 staff members and place in wheelchair. Nonskid socks place on resident feet. VS: 147/72 96 18 95%RA 98.2. POA/MD Costa/Oncoming Staff notified ". The post fall assessment was completed by E4, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 4/22/25 - Per EMR entry at 5:53 PM, E4 (LPN) wrote [sic]" Staff requested this writer to resident apartment due to unwitnessed fall, upon arrival resident found by apartment doorway. Resident noted fully dress with socks on feet, noted laying on back with arms at side and legs straight in front of resident. Wheelchair noted by bed. Resident denied hitting head. No injuries noted. Resident assisted to feet and placed in wheelchair.		

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	POA/NP Coleman/Oncoming Staff notified. VS: 136/74 97 19 97.4 95%RA" The post fall assessment was completed by E4, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 4/24/25 - Per EMR entry at 12:28 AM, E25 (LPN) wrote [sic]" Resident was found on the floor this shift by CNA during last rounds this evening. CNA calls this writer to report Resident on the floor. This writer arrives to find Resident lying on his back. Resident took adult brief off and was attempting to place pants and a jacket on. An abrasion noted to Right side of his forehead. Similar to a rug burn. Red in color. ROM WNL. At baseline for Resident. 3 person assist Resident to w/c then to bed and cleaned up. B/P 132/78.hr 84, rr 20, t 98.2 and SPO2 96% on ra. First aide applied to forehead. Resident c/o Mild low back pain. PRN medication administered per MAR. POA/TeamHealth/Dir/DON notified". The post fall assessment was completed by E25, not an RN as required by the Delaware State 5regulation of the Board of Nursing Scope of Practice. 3. 8/14/23 – R7 was admitted to the facility. 1/3/25 – Per EMR entry at 11:54 AM, E27 (LPN) wrote [sic]" Caregiver was doing rounds this morning and found resident on the floor and called writer. Upon arrival to resident apartment resident was lying on his back on the floor in front his bed with his head towards the bed head and feet towards the bed foot, with walker at the bed foot. Resident had on plain white socks and did not use his pendant or call for help. Resident said he was getting out off bed to use the bathroom and he slid down to the floor. Resident		

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	denied hitting head, no complaints of pain or discomfort, skin intact and he tolerated range of motion to all extremities. Resident assisted to feet and ambulated to bathroom via walker. Resident was reeducated by this writer to use the pendant to call for help at all times. POA , MD, and Oncoming Staff notified. VS: 152/76, 61, 17, 97.8 & 98%RA". The post fall assessment was completed by E27, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 1/26/25 – Per EMR entry at 5:54 AM, E25 (LPN) wrote [sic]" Received call from CNA that Resident was found on the floor next to bed during rounds. Arrive to find Resident laying on his back, in between his walker, next to his bed. Resident is A/O x3. Able to make needs known. ROM equal BUE and BLE. Resident reports no injury. No open areas or pain noted at this time. B/P 143/73, HR 92, RR 20, T 96.4 and SPO2 98% on ra. BM residual noted on the floor. Resident is able to lift self-off floor with two persons assist. Resident assisted to seated position on the side of the bed. Black socks noted on feet. CNA changes to non-slip socks. Resident is assisted back to bathroom to finish cleaning his buttocks. Gait is unsteady with walker. Asked Resident if he would like an evaluation from E.R. Resident is adamant about not going to hospital. Resident is educated on using pendant when need of assist and states he is fine. POA notified and message is left. Team Health/DON notified". The post fall assessment was completed by E25, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice.		

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	1/30/25 - Per EMR entry at 3:06 AM, E26 (LPN) wrote [sic]" Call to room by CNA, stating that resident was on the floor. Primary CNA stated that she heard resident calling for help and when she entered the room, resident was seen on the floor. Resident was found by the bathroom laying on his back. Resident is unable to state that happen and how he got on the floor. He just stated that he is waiting for an xray. He denies hitting his head and denies any pain. B/P 179/93, HR 88, RR 18, T 97.1 O2=95%" The post fall assessment was completed by E26, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 2/22/25 - Per EMR entry at 9:19 PM, E25 (LPN) wrote [sic]" This writer arrive to room 234 for Hs medication administration. Resident was found on the floor with a blanket behind his head. Resident was located by the foot of the bed. A bottle of Gaterade located on the floor in front of the bathroom. W/C unlocked beside him. Resident not able to recall how he got into the position or how long he was in that position. ROM WNL to BUE and BLE. No injury/bruising observed. Resident states he did not hit head. B/P 129/66, HR 61, RR 18, T 98.0 and SPO2 95% on ra. Slip socks on both feet. CNAs notified to assist to w/c. POA/MC ADON/Team Health notified. The post fall assessment was completed by E25, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 4. 7/21/22 -R10 was admitted to the facility. 12/18/24 Per EMR entry at 5:54 AM, E25 (LPN) wrote [sic]" CNA called this writer to		

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	state Resident is on the floor next to his bed. Arrive to find Resident sitting on his buttocks beside his bed with cane. No socks on. Resident states he was going to the bathroom and lost his balance trying to put his shoes on. Resident presents with a 4to 5cm by 4to 5cm skin tear to the Right elbow. Resident states he hit his elbow on the bedside table but did not hit his head. VS B/P 153/68, HR 66, RR 22. T 98.4 and Spo2 94% ra. ROM completed. Resident is assisted to sitting on the side of his bed and he requested his rollator at this time. First aide applied to Right elbow. Team Health/DON/POA, Daughter Mona notified". The post fall assessment was completed by E25, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 5/20/25– Per interview with E2 (HCD) at approximately 12:30 PM, E2 confirmed the LPNs are performing post fall assessments. E2 stated the LPN will call or message her when a resident fall occurs. 5/21/25 - Findings were reviewed with E1 (ED), E2, E10 (RDRC), E11 (RDO), E12 (RHR) and E13 (SVP) at the exit conference, beginning at approximately 3:30 PM.		
3225.18.0 **3225.18.4** **S/S – E**	**Emergency Preparedness** **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:	3225.18.4 A. E19 remains employed in community. Community was not able to locate documentation emergency preparedness education was completed.	7/05/2025

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DELAWARE HEALTH AND SOCIAL SERVICES

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

DHSS - DHCQ
263 Chapman Road, Suite 200, Cambridge Bldg.
Newark, Delaware 19702
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STATE SURVEY REPORT

NAME OF FACILITY: AL- Harmony at Kent

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	Based on interview and review of other facility documentation, it was determined that three (E18, E19 and E22) out of five employees' training record review, the facility failed to provide evidence of the Emergency Preparedness education. Findings include: 1. 10/11/23 – E18 (MT) was hired. The facility had no evidence of Emergency Preparedness training. 2. 9/13/23 - E19 (CNA) was hired. The facility had no evidence of Emergency Preparedness training. 3. 1/15/24 – E14 (CNA) was hired. The facility had no evidence of Emergency Preparedness training. 5/21/25– Per interview with E9 (BD) at approximately 11:00 AM, E9 confirmed the Emergency Preparedness training was not in evidence for these employees. 5/21/25 - Findings were reviewed with E1 (ED), E2(HCD), E10 (RDRC), E11 (RDO), E12 (RHR) and E13 (SVP) at the exit conference, beginning at approximately 3:30 PM.	E22 remains employed in community. Community was not able to locate documentation emergency preparedness education was completed. E9 remains employed in community. Community was not able to locate documentation emergency preparedness education was completed. B. All residents have the potential to be affected by this deficient practice. C. A root cause analysis revealed the required education trainings for "Emergency Preparedness" was not being properly monitored for compliance due to leadership turnover. An education audit for all current staff was completed on 6/9/25 and all staff will complete "Emergency Preparedness" training by 7/05/2025. D. The ED/designee will conduct a weekly audit for all staff, including new hires, for x4 weeks, until 100% compliance is verified then monthly x2 until 100% verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation.	

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