

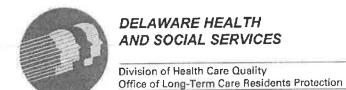
STATE SURVEY REPORT

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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 Sur-		
	vey was conducted at this facility from May		
	19, 2025, through May 21, 2025. The defi-		
	ciencies contained in this report are based on		
	interview, record review and review of other		
	facility documentation as indicated. The facil-		
	ity census on the first day of the survey was		
	eighty-one (81). The survey sample totaled		
	ten (10) residents plus two (2) additional sub-		
	sampled 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 resi-		
	dent's physical, medical, and psychosocial		
	status as documented in a Uniform Assess-		
	ment 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 in-		
	clude: lodging, board, housekeeping, per-		
	sonal care, and supervision services;		
	SD – Sales Director;	Title EXECUTIVE Director Date 6/2	- 1



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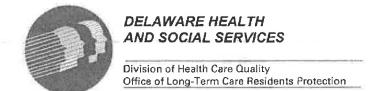
NAME OF FACILITY: AL- Harmony at Kent

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	SVP – Senior Vice President of Operations;		
	UAI (Uniform Assessment Instrument) - A	B B 2	
	document setting forth standardized criteria		
	developed by the Division to assess each res-		
	ident's functional, cognitive, physical, medi-		
	cal, 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	7/05/2025
3225.5.12	An assisted living facility that provides direct	A. E19 remains employed in community.	
	healthcare services to persons diagnosed as	Community was not able to locate	
S/S- D	having Alzheimer's disease or other forms of	documentation dementia education was	
	dementia shall provide dementia specific	completed.	
	training each year to those healthcare pro-	E22 remains employed in community.	
	viders who must participate in continuing	Community was not able to locate	
	education programs. The mandatory train-	documentation dementia education was	
	ing must include communicating with per-	completed.	
	sons diagnosed as having Alzheimer's dis-	D. Allid- abs have the metantial to be	
	ease or other forms of dementia; the psy-	B. All residents have the potential to be	
	chological, social, and physical needs of	affected by this deficient practice.	
	those persons; and safety measures which	C. A root cause analysis revealed the required	
	need to be taken with those persons. This	education trainings for "Dementia" was not	
	paragraph shall not apply to persons certi-	being properly monitored for compliance due	
	fied to practice medicine under the Medical	to leadership turnover. An education	
	Practice Act, Chapter 17 of Title 24 of the	audit for all current staff was completed on	
	Delaware Code.	6/9/25 and all staff will complete "Dementia"	
		training by 7/05/2025.	
	This requirement was not met as evidenced		
	by:	D. The ED/designee will conduct a weekly	
		audit for all staff, including new hires, for x4	
	Based on interview, record review and re-	weeks, until 100% compliance is verified then	
	view of other facility documentation, it was	monthly x2 until 100% verified. Results will be	
	determined that for two (E19 and E22) out of	presented to the Quality Assurance Process	
	five sampled employees, the facility failed to	Improvement team for review and recommendation.	
		recommendation.	

Provider's Signature

Title Executive Director Date 6/26/2025



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	provide evidence of the mandated annual de-		
	mentia 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.	7 . U	
3225.9.0	Infection Control		
3225.9.5	Requirements for tuberculosis and immunizations:	3225.9.5 A. E7 remains employed in community. Community was not able to locate documentation pre-hire TB was administered.	7/05/25
3225.9.5.2	Minimum requirements for pre-employ-	E8 remains employed in community.	
	ment require all employees to have a base	Community was not able to locate	
5/\$ – E	line two step tuberculin skin test (TST) or	documentation pre-hire TB was administered.	
	single Interferon Gamma Release Assay	E14 remains employed in community. Community was not able to locate	
	(IGRA or TB blood test) such as QuantiFeron.	documentation pre-hire TB was administered.	
	Any required subsequent testing according	E15 is no longer employed with community.	
	to risk category shall be in accordance with the recommendations of the Centers for Dis-	Community was not able to locate	
	ease Control and Prevention of the U.S. De-	documentation pre-hire TB was administered.	
	partment of Health and Human Services.	E16 remains employed in community.	
	Should the category of risk change, which is	Community was not able to locate documentation pre-hire TB was administered.	
	determined by the Division of Public Health,	E17 is no longer employed with community.	
		Community was not able to locate	
		documentation pre-hire TB was administered.	02



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

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SECTION

STATEMENT OF DEFICIENCIES

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ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED

Completion Date

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:

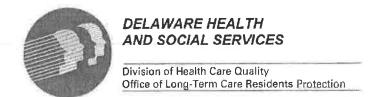
Based on record review, interview and review of other facility documentation, it was determined that for six (E7, E8, E14, E15, E16 and E17) out of seven sampled employee records, pre-hire tuberculin testing per the State regulation was not in evidence. Findings include:

- 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.

Provider's Signature

Title Executive Director Date 6/26/2025



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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
3225.9.6 \$/\$ -E	5/21/25 – Per interview with E9 (BD) at approximately 11:00 AM, E9 confirmed the prehire testing was not in evidence. 5/21/25 - Per interview with E1 (ED) at approximately 3:00 PM, E1 confirmed the prehire 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. 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. 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

Provider's Signature

Title Executive Director Date 1/20/2025



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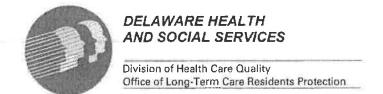
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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	1. 8/31/23 - R1 was admitted to the facility. The facility lacked evidence that the 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)	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	and E13 (SVP) at the exit conference, beginning at approximately 3:30 PM. The assisted living facility shall have on file evidence of vaccination against pneumococcal pneumonia for all residents older than 65 years, or those who received the pneumococcal vaccine before they became 65 years and 5 years have elapsed, and as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against pneumococcal pneumonia must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.	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. Title Executive Director Date W20	7/05/2025



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NAME OF FACILITY: AL-Harmony at Kent

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ADMINISTRATOR'S PLAN FOR Completion **CORRECTION OF DEFICIENCIES WITH**

DATE SURVEY COMPLETED: May 21, 2025

"Pneumococcal Vaccine Timing for Adults-
Adults >/= 65 years old Complete pneumo-
coccal vaccine schedules PCV13 only at any
age- Option A: >/= 1 year, give PVC20, Op-
tion B: >/= 1 year, give PP\$V23." U.S. De-
partment of Health and Human Services,

STATEMENT OF DEFICIENCIES

SPECIFIC DEFICIENCIES

This requirement was not met as evidenced by:

Centers for Disease Control and Prevention.

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.

ANTICIPATED DATES TO BE CORRECTED

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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NAME OF FACILITY: AL- Harmony at Kent

Office of Long-Term Care Residents Protection

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	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.		

Provider's Signature

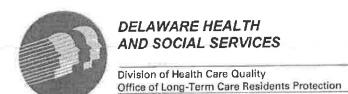
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3225.11.0 3225.11.2 S/S -D	Resident Assessment A resident seeking entrance shall have an initial UAI-based resident assessment completed by a registered nurse (RN) acting on behalf of the assisted living facility no more than 30 days prior to admission. 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.	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. Service Agreements	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
3225.13.1 S/S – E	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

Provider's Signature 🚾

Title Executive Directer Date 6/26/2025



STATEMENT OF DEFICIENCIES

SPECIFIC DEFICIENCIES

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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.

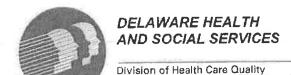
R9 continues to reside in the community. Community was not able to locate the signed service plan. A current and signed service plan will be in place by 6/30/25.

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

Provider's Signature

Title Executivebirectes Date (0/26/2025



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STATE SURVEY REPORT

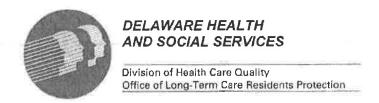
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DATE SURVEY COMPLETED: May 21, 2025

	STATEMENT OF DEFICIENCIES	ADMINISTRATOR'S PLAN FOR	Completion
SECTION	SPECIFIC DEFICIENCIES	CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Date
3225.13.3 S/S – E	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. 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 listed. R6 service plan has been updated to include attending physician information.	7/05/2025

Provider's Signature

Title Executive Director Date 4/20/2025



STATE SURVEY REPORT

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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
	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.	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.	
	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 ap-	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.	
	proximately 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.		

Provider's Signature

Title Executive Director Date 4/24/2025



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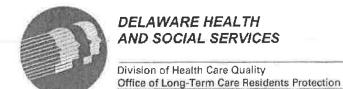
NAME OF FACILITY: AL- Harmony at Kent

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
3225.14.0	Resident Rights	3225.14.0	7/05/2025
3223.14.0		A. R1 no longer resides in the community, has	
225.14.1	Assisted living facilities are required by 16	since expired. Community was not able to pro-	
	Del.C. Ch. 11, Subchapter II, to comply with	vide a signed updated Resident Rights docu-	
/S – E	the provisions of the Rights of Patients cov-	ment.	
	ered therein.	R5 continues to reside at the community.	
	and a second cutting about the firm	Community was not able to provide a signed	
el.C. Ch	(b) Copies of § 1121 of this title shall be fur-	updated Resident Rights document.	
1, Sub-	nished to the resident upon admittance to	R6 continues to reside at the community.	
hapter II	the facility; all residents currently residing in	Community was not able to provide a signed	
§ 1121.	the facility; and the authorized representa-	updated Resident Rights document.	
esident's	tive under § 1122 of this title. The long-term	R7 continues to reside at the community.	
ights.	care facility shall retain in its files a state-	Community was not able to provide a signed	
	ment signed by each person listed in this	updated Resident Rights document.	
1123.	subsection that the person has received a	R8 continues to reside at the community.	
lotice to	copy of § 1122 of this title.	Community was not able to provide a signed	li i
atient.	Tit was been not mot as avidanced	updated Resident Rights document. R9 continues to reside at the community.	
	This requirement was not met as evidenced	Community was not able to provide a signed	
	by:	updated Resident Rights document.	
	Based on record review and interview, it was	R10 continues to reside at the community.	
	determined for seven (R1, R5, R6, R7, R8, R9	Community was not able to provide a signed	
	and R10) out of ten residents reviewed for	updated Resident Rights document.	
	updated resident rights notification, the facil-	updated hesident rights december	
	ity failed to ensure that the resident or resi-	B. Newly admitted residents and current resi-	
	dent representative was notified and signed	dents have the potential to be affected by this	
	off on the updated resident rights form. Find-	deficient practice.	1.
	ings include:	C. A root cause analysis revealed the need for	
	The Resident Rights form (updated Septem-	administration to update company	
	ber 2023) required each resident or resident	documents to the most current version of the	
	representative to sign and date acknowledg-	Resident Rights document. This was corrected	
	ing the receipt of a copy of the updated Resi-	on 5/21/25. Current residents will receive the	
	dent Rights.	correct version to review and sign by 7/05/25.	
			r.
	1. 8/31/23 – R1 was admitted to the facility.	D. The ED/designee will conduct a weekly au-	
	The facility was unable to provide any docu-	dit for all new admissions for x4 weeks, until	
	mentation of R1 or R1's resident representa-	100% compliance is verified then monthly x2	
	tive being notified and signing off on the up-	until 100% verified. Results will be presented	
	dated Resident Rights form.	to the Quality Assurance Process Improvement team for review and recommendation.	

Provider's Signature

Title Expartive Director Date 4/20



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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
	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.		
6	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.		9
	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-		

Provider's Signature

Title Executive archer Date 4/20/2025



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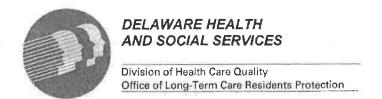
NAME OF FACILITY: AL- Harmony at Kent

DATE SURVEY COMPLETED: May 21, 2025

		ANTICIPATED DATES TO BE CORRECTED	
3225.16.0 3225.16.2 6/S- E	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. 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

Provider's Signature

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NAME OF FACILITY: AL- Harmony at Kent

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STATEMENT OF DEFICIENCIES
SECTION SPECIFIC DEFICIENCIES

ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED

Completion Date

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.

Title EVELVIVE DIrector Date (0/2/4/2025

Provider's Signature



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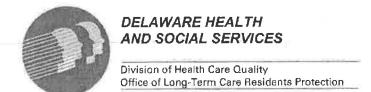
NAME OF FACILITY: AL- Harmony at Kent

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
	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		

Provider's Signature

Title Exclutive arecter Date 4/26/2025



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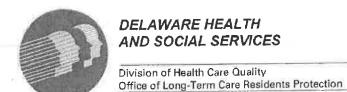
NAME OF FACILITY: AL- Harmony at Kent

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
	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.		

Provider's Signature

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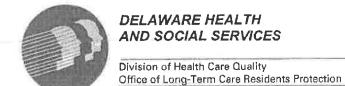
NAME OF FACILITY: AL- Harmony at Kent

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
	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 5 regulation 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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Title Exclusive Olyceter Date 6/20/2025



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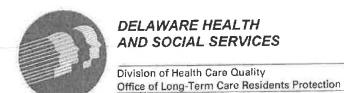
NAME OF FACILITY: AL- Harmony at Kent

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
	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.		

Provider's Signature

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NAME OF FACILITY: AL-Harmony at Kent

Provider's Signature

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	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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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	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 \$po2 94% ra. ROM completed. Resident is assisted to sitting on the side of his bed and he requested his rollator	ANTICIPATED DATES TO BE CONNECTED	
	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	Emergency Preparedness		
3225.18.4 5/S – E	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.	3225.18.4 A. E19 remains employed in community. Community was not able to locate documentation emergency preparedness	7/05/2025
	This requirement was not met as evidenced by:	education was completed.	



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SECTION

STATEMENT OF DEFICIENCIES

SPECIFIC DEFICIENCIES

ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED Completion Date

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:

Office of Long-Term Care Residents Protection

- 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.

Provider's Signature

Title Executive arceter Date 4/26/2025