STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. Building B. Wing	12/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kentmere Rehabilitation and Healthcare Center	1900 Lovering Avenue Wilmington, DE 19806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview, record review, document review, and facility policy review, the facility failed to timely report an allegation of abuse to the state survey agency that involved 2 (Resident #11 and Resident #19) of 7 sampled residents reviewed for abuse. The facility further failed to ensure staff immediately reported an allegation of abuse to the Director of Nursing and/or Executive Director for 3 (Residents #18, #34, and #37) of 7 sampled residents reviewed for abuse. Findings included:A facility policy titled, Abuse, Neglect, Mistreatment, Misappropriation, Exploitation and Reasonable Suspicions of Crime, updated 10/2019, revealed, Allegations of resident abuse shall be reported to the appropriate state regulatory authority within 2 hours.1. An admission Record revealed the facility admitted Resident #11 on 08/04/2021. According to the admission Record, the resident had a medical history that included diagnoses of neurocognitive disorder with Lewy bodies, dementia without behaviors, and mild cognitive impairment. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/12/2025, revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. Resident #11's progress note dated 07/17/2025 at 12:13 PM, indicated the resident became physically aggressive with another resident. Facility documentation indicated the facility notified the state survey agency of an incident that involved Resident #11 and Resident #19 on 07/17/2025 at 3:48 PM, four and a half hours after the incident occurred. During an interview on 12/11/2025 at 11:33 AM, the Director of Nursing (DON) stated the facility had two hours to report abuse to the state agency. During a follow-up interview on 12/11/2025 at 3:53 PM, the DON stated the incident that involved Resident #11 and Resident #19 was not submitted within two hours to the state survey agency and it should have been. 2. An admission Record revealed the facility admitted Resident #18 on 08/28/2024. According to the admission Record, the resident had a medical history to include a diagnosis of cognitive communication deficit. An annual Minimum Data Set (MDS), with an Assessment Reference Data (ARD) of 09/06/2025, revealed Resident #18 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. An admission Record revealed the facility admitted Resident #37 on 09/22/2023. According to the admission Record, the resident had a medical history to include a diagnosis of dementia. An annual MDS, with an ARD of 09/29/2025, revealed Resident #37 had a BIMS score of 3, which indicated the resident had severe cognitive impairment. The facility incident summary report indicated on 05/08/2025 at 9:30 PM, Resident #18 touched the breast of Resident #37. Per the facility incident summary report, this incident was not reported to the state survey agency until 05/09/2025 at 2:25 PM. During an interview on 12/10/2025 at 2:56 PM, the Director of Nursing (DON) stated she was notified on 05/09/2025 of the resident-to-resident sexual abuse incident between Resident #18 and Resident #37 that occurred on 05/08/2025. The DON stated the incident was reported to the state agency on 05/09/2025. The DON stated she should have been notified on 05/08/2025 of the incident. The DON stated Licensed Practical Nurse (LPN) #20 did not follow the notification process for allegations of abuse and was no longer employed by the facility. During an interview on 12/11/2025 at 11:33 AM, the Executive Director (ED) stated she was not in the facility at the time of the resident-to-resident sexual abuse incident between Resident #18 and Resident #37 that occurred on 05/08/2025. The ED stated LPN #20 notified the DON the next day, 05/09/2025, about the incident of sexual abuse between Resident #18 and Resident #37 and said that she forgot to contact the DON to notify her of the incident when it occurred. The ED stated she was also notified by the DON on 05/09/2025, which was also the day the incident was reported to the state survey agency. The ED stated the incident should have been reported to the state agency on 05/08/2025 within two hours of the incident.3. An admission Record revealed the facility admitted Resident #34 on 10/24/2024. According to the admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD), anxiety, traumatic brain injury, and asthma.An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/31/2025, revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. Resident #34's Care Plan Report included a focus area that indicated the resident was at risk for complications related to asthma and COPD, with an intervention that directed staff to give medications as ordered (initiated 10/24/2024).The incident report form dated 10/07/2025, revealed the facility identified on 10/07/2025 at 1:09 PM that Resident #34 had bruising and swelling to their right pointer finger and knuckles. The report revealed the resident reported to the Director of Nursing (DON) and Assistant Director of Nursing that the injury resulted when

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview, record review, document review, and facility policy review, the facility failed to interview all persons identified as involved or with knowledge of an occurrence for 2 (Resident #34 and Resident #93) of 7 sampled residents reviewed for abuse. Findings included:A facility policy titled, Abuse, Neglect, Mistreatment, Misappropriation, Exploitation and Reasonable Suspicions of Crime, updated 10/2019, indicated, Investigation *All alleged incidents involving abuse, neglect, mistreatment, misappropriation of resident property, or exploitation, including injuries of unknown source, shall be reported to the NHA [nursing home administrator] or designee immediately. *The NHA or designee will investigate allegations and report to appropriate regulatory agencies. *All persons identified as involved in or with knowledge of the occurrence will be interviewed.1. An admission Record revealed the facility admitted Resident #34 on 10/24/2024. According to the admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD), anxiety, traumatic brain injury, and asthma.An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/31/2025, revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The facility investigation revealed the facility identified Resident #34 had a bruise and swelling to their finger on 10/07/2025. The investigation indicated that Resident #34 reported to the Director of Nursing (DON) that on 10/07/2025 at 3:30 PM, Licensed Practical Nurse (LPN) #8 caused the bruise by pulling Resident #34's inhaler out of their hand. The facility investigation included an interview with Resident #34, an interview with LPN #8, and statements from staff who worked with Resident #34. The facility investigation included information that a certified nurse aide reported that Resident #34 told a therapist that they had hit their hand. The facility investigation did not include statements from the therapist. During an interview on 12/11/2025 at 12:03 PM, the Speech Language Pathologist (SLP) stated he worked with Resident #34 on 10/03/2025 and 10/07/2025. The SLP stated he vaguely remembered Resident #34 mentioning having an incident with a staff member where the resident stated they tried to grab something but the staff member grabbed it from them.During an interview with the DON and Assistant DON on 12/12/2025 at 2:22 PM, the DON stated that she would expect any staff that worked with Resident #34 within 24 hours of the bruise being identified to be interviewed.During an interview on 12/12/2025 at 3:29 PM, the Executive Director stated she expected an abuse investigation to include statements from anyone who worked with the resident in the previous 72 hours to try to determine what happened as quickly as possible.2. An admission Record revealed the facility admitted Resident #93 on 08/11/2023. According to the admission Record, the resident had a medical history that included diagnoses of dementia, osteoporosis, glaucoma, muscle weakness, and history of falling.An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/28/2025, revealed Resident #93 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment.Resident #93's nurse's note written by Licensed Practical Nurse (LPN) #13 and dated 05/15/2025 at 5:35 PM, indicated the resident's index finger was bruised, swollen, and warm to the touch.The facility investigation revealed Resident #93's sustained a fracture of unknown origin. The facility investigation did not include statements from Registered Nurse #12 or LPN #13.During an interview with the Director of Nursing (DON) and Assistant DON on 12/12/2025 at 2:22 PM, the ADON stated the facility interviewed all staff that worked with Resident #93, but she should have gone back 24 hours from the time the bruise was identified and interviewed those staff members that worked with Resident #93. The ADON stated they did not have a statement from RN #12.During an interview on 12/12/2025 at 3:29 PM, the Executive Director stated whenever there was an injury of unknown origin, there was a 72-hour look-back period, and the facility should get statements from anyone who worked with the resident during that period

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, facility document review, and facility policy review, the facility failed to:1. Provide supervision to prevent a fall for 1 (Resident #110) of 3 residents reviewed for falls. While providing care to Resident #110 on [DATE], Certified Nurse Aide (CNA) #16 turned her back to the resident and the resident jerked and fell to the floor. Initially, the resident was transferred to a hospital and received four sutures for a skin tear to the left side of their forehead. Two days later, on the morning of [DATE], CNA #16 noted swelling to resident #110's left hip and thigh and the resident had limited range of motion (ROM) to the left leg. The resident's physician was notified, and an x-ray was obtained, which revealed a fracture and displacement to the resident's left femur (hip area). After consultation with the resident's Responsible Party (RP) regarding the resident not being a candidate for hip surgery, the RP chose not to send the resident to the hospital and initiated comfort care measures and pain management at the facility. Resident #110 expired in the facility on [DATE].2. Identify and remove an accident hazard from 1 (Resident #62's room) of 25 rooms on the 300 Unit, which was the dementia unit. Specifically, an observation on [DATE] revealed broken glass in a picture frame in Resident #62's restroom. Interviews revealed that a staff member observed the broken picture frame on [DATE]; however, no action was taken to remove the broken glass. Findings included:A facility policy titled, Accidents and Supervision, dated [DATE], indicated, Policy Explanation and Compliance Guidelines: The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. I. Identification of Hazards and Risks - the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. a. All staff (e.g., professional, administrative, maintenance, etc.) are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident. The policy also revealed, 5. Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. 1. Resident #110's admission Record indicated the facility admitted the resident on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease, muscle weakness (generalized), cognitive communication deficit, unilateral primary osteoarthritis of the right knee, the need for assistance with personal care, and repeated falls.A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #110 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on staff for toileting and personal hygiene, bathing, dressing, rolling left to right in bed, moving from sitting to lying position, moving from lying to sitting on the side of the bed, and chair-to-bed transfers. Resident #110's Care Plan Report included a focus area initiated [DATE], that indicated the resident had an activity of daily living (ADL) self-care performance deficit related to Alzheimer's disease and impaired balance. Interventions (revised [DATE]) directed staff that the resident was dependent on at least one staff member to provide a bath or shower; dependent on staff to turn from side to side, sit up and lie down, and reposition in bed; dependent on staff for incontinence care, changing their brief, and clothing management; and dependent on two staff to move between surfaces.A facility FRI [Facility Reported Incident] 5 day Follow Up Report, dated [DATE], indicated that on [DATE], during morning care, the resident fell when a CNA (CNA #16) turned to obtain a washcloth from the cart. Per the FRI, CNA #16 reported that as soon as they turned their back, Resident #110 jerked off the bed. It happened so fast. The report revealed the resident was transferred to the hospital for a laceration to the forehead and a computed tomography (CT) scan of the head and cervical spine and returned with stitches to the forehead. According to the FRI report, on [DATE] at 8:30 AM, staff noted that Resident #110 had left hip/thigh swelling. The report revealed staff notified the physician and an x-ray was ordered of the bilateral hips, left tibia and fibula. Per the report, the x-ray revealed that Resident #110 had a fracture involving the proximal left femur with displacement. The facility's report also revealed that a provider discussed the hip x-ray results and treatment with the resident's power of attorney (POA) and due to being bed/wheelchair bound and having end stage dementia, the family chose comfort care/pain management with no hospitalization.Resident #110's [DATE] Medication Administration Record [MAR] revealed staff documented that the resident had no pain on [DATE] through [DATE]. The MAR revealed staff documented that the resident had a pain level of 2 (with 0 being no pain, and 10 being the worst pain

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and facility policy review, the facility failed to ensure they had an effective pest control program to address the infestation of rodents on 1 (3rd floor) of 4 floors in the facility. Findings included:A facility policy titled, Pest Control Program, revised 12/21/2024, indicated, Policy: It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents. Per the policy, Policy Explanation and Compliance Guidelines: 1. Facility will maintain a written agreement with a qualified outside pest service to provide comprehensive pest control services on a regular and scheduled basis. 2. Facility will ensure that appropriate chemicals are used to control pests but can be used safely inside the building without compromising resident health. 3. Facility will maintain a report system of issues that may arise between scheduled visits with the outside pest service and treat as indicated.During an observation on the 3rd floor on 12/09/2025 at 4:10 PM, there was a sticky trap with evidence of rodent droppings in the dining room by one of the windows opposite the entrance to the dining rom. There was evidence of rodent droppings behind the fish tank in the common room. Also noted was rodent droppings in room [ROOM NUMBER] behind the entry door. There was evidence of rodent droppings under a large dresser in the right corner of room [ROOM NUMBER]. There was evidence of rodent droppings under the large dresser that was tucked into a cubby as well as the back wall near the heating/cooling unit in room [ROOM NUMBER]. During an observation of the dining room on the 3rd floor on 12/13/2025 at 8:15 AM, a live mouse was seen under one of the tables.During an interview on 12/10/2025 at 1:25 PM, Certified Nurse Aide (CNA) #1 stated she had been employed by the facility since 2021. According to CNA #1, mice in the facility came out at night, especially in room [ROOM NUMBER].During an interview on 12/11/2025 at 1:53 PM, the Director of Maintenance (DOM) stated he had worked in the facility for the past two and a half years. The DOM stated residents and staff would report pest sightings and the pest control company would be notified. According to the DOM, sticky traps were placed around the perimeter of the facility to catch the mice. The DOM acknowledged he was very much aware of the various complaints about mice and other rodents in the facility. During an interview on 12/11/2025 at 3:00 PM, the Executive Director stated she was aware of the rodent issue in the facility and acknowledged it had been a problem for the past year. During an interview on 12/12/2025 at 10:02 AM, the Director of Nursing stated the facility had been addressing the pest control issue and recently changed pest control companies.