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 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. **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 (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 0689 Level of Harm - Actual harm Residents Affected - Few	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 imaginable) on [DATE]. Per the MAR, acetaminophen 500 milligrams (mg), two tablets three times per day, was started on [DATE] at 1:00 PM. The MAR revealed the resident had a pain level of 6 on [DATE], a pain level of 5 on [DATE], and a pain level of 4 on [DATE]. Resident #110's August MAR revealed staff documented that the resident had no pain.Resident #110's Radiology Results Report dated [DATE] revealed bilateral hip x-rays indicated the resident had a recent facture involving the proximal left femur with displacement. CNA #16's personnel file revealed an Employee Disciplinary Notice dated [DATE], that indicated the employee was given a written warning related a fall incident on [DATE]. The notice indicated that CNA #16 turned to get a washcloth off a cart, which was located away from the resident, when the fall occurred. The Employee Disciplinary Notice revealed that on [DATE], the resident was noted with left hip/thigh swelling, and an x-ray was ordered. On [DATE], the results were received, which indicated a fracture of the left femur. The notice concluded that Due to the negligent practice during daily care the resident sustained an injury, and that any further actions of that type would result in progressive discipline up to and including termination. A Memorandum dated [DATE] to CNA #16 revealed the director met with the CNA concerning resident safety and protocols when providing bed baths, showers, perineal care, or other tasks. Per the Memorandum, the resident's bed could be raised to a height that was ergonomically correct for the task to prevent staff injury. However, staff could not leave the resident unattended at any time when the bed was raised. According to the Memorandum, leaving a bed at a raised height put the resident at risk of falling out of bed and getting injured. The Memorandum revealed, To prevent injury, staff MUST lower the bed to its lowest position when leaving the bedside for any reason, regardless of how short a distance away from the resident or length of time. Additionally, it is best practice to gather necessary supplies and linen needed to provide the required care. During a telephone interview on [DATE] at 9:49 PM, Resident #110's RP stated that Resident #110 had been declining before the fall on [DATE]. The RP stated they were in the facility when the resident's physician saw the resident post fall. The RP stated that the facility obtained an x-ray, which revealed a broken hip. According to the RP, the physician spoke with them, and since the resident was not a good candidate for surgery due to their weight and decline, they chose in-house hospice care. The RP stated that the resident was not the same after the fall. The RP stated they felt that nursing staff should have been providing care in pairs because of the resident's movement. Telephone interviews were attempted with CNA #16 on [DATE] at 8:39 AM, at 1:30 PM, at 2:34 PM, and at 2:35 PM. A voicemail was able to be left at 2:34 PM on [DATE]; however, no return call was received prior to exiting the survey.During an interview on [DATE] at 2:36 PM, the Executive Director (ED) stated that CNA #16 was on (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	vacation.During a telephone interview on [DATE] at 3:18 PM, RN #18 stated CNA #16 told her the resident fell out of bed and she assessed the resident after the fall on [DATE]. She stated CNA #16 told her that she had turned away from the resident and the resident fell out of bed. She stated the resident had a cut on their head and was sent to the hospital. She stated that the resident indicated no pain in their hips or thighs during assessment. During an interview on [DATE] at 1:49 PM, Licensed Practical Nurse (LPN) #23 stated Resident #110 had been on the unit for a long time and was wheelchair bound. He stated the resident had jerking movements when in the bed while care was being provided, as well as in their wheelchair. He stated he was working on [DATE] when the resident's x-ray results came back and showed a fracture of the resident's left extremity. He stated the family was notified, and they chose to provide comfort care for the resident and not transfer the resident to the hospital. He stated he spoke with the physician, who ordered extra strength Tylenol for pain. According to LPN #23, Resident #110 had been declining and was not their usual self before the fall.During an interview on [DATE] at 1:25 PM, CNA #1 stated that she was not on shift when the fall occurred on [DATE]. She stated Resident #110 would throw themselves to one side of the bed and jerked their body around. She stated that when providing care for residents who jerked, she stayed at the side of the bed, so they did not fall.During an interview on [DATE] at 2:15 PM, LPN #22 stated Resident #110 was nonverbal, dependent on staff for care, and used a Hoyer lift for transfers. She stated the resident required two people for transfers but not for ADL care. LPN #2 stated that the resident had jerking movement when in bed and in their wheelchair. She stated the resident had been declining before the fall and had a decrease in appetite. During an interview on [DATE] at 12:19 PM, the Medical Director (MD) stated Resident #110 had been in the facility since 2019 and did not have a history of frequent falls or unsafe transfers. She stated the resident had a fall on [DATE] that resulted in a fracture. She stated the resident was sent to the hospital after the fall, and she saw the resident when the resident returned to the facility. The MD stated the resident was sitting in their wheelchair for the examination and had swelling and frowned when range of motion of the lower left extremity was assessed. She stated an x-ray was ordered and a fracture was found. She stated the resident had end stage of dementia, was not doing well, and was not a candidate for hip surgery. She stated that the resident's RP elected to place the resident on comfort care. During an interview on [DATE] at 3:28 PM, the Director of Nursing (DON) stated CNA #16 notified her that Resident #110 had jerking movements, which were normal for the resident, that caused the resident to fall out of bed. She stated CNA #16 told her that she had turned around to grab an item, and when she turned back around, the resident had fallen out of bed. Per the DON, the facility concluded negligence because the bed should be lowered to the floor and fall mats replaced at the bedside if staff had to leave the resident during care. The DON stated facility CNAs were trained to gather all their supplies and anticipate the needs of the resident before providing care to prevent these incidents. She stated the fall that resulted in the disciplinary action for CNA #16 could have been prevented. The DON stated that initially, Resident #110 indicated no pain to their lower extremities or hips and was transferred to the hospital, where they scanned the resident's head and neck and found no injury. She stated that on [DATE], while CNA #16 was providing care to the resident, she noticed swelling to their thigh and notified the nurse. Per the DON, the physician came in to assess the resident and after the fracture was found, Resident #110's RP opted for comfort care. She stated Resident #110 had osteoarthritis, which could affect the strength of their bones. She stated that the resident had also experienced a decline before the fall in [DATE]. During a follow-up interview on [DATE] at 11:22 AM, the DON stated she felt CNA #16 made a mistake and was not careful with Resident #110 on [DATE], but there was nothing intentional about her actions. She stated she had no prior knowledge of the resident's jerking movements until she investigated the fall and spoke with CNA #16. She stated she had not witnessed those movements from the resident.During an interview on [DATE] at 3:08 PM, the ED stated that Resident #110 went to the hospital after the fall. She stated when staff noticed the resident was grimacing upon return from the hospital, a hip x-ray was completed, which indicated a (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	fracture. She stated the resident had no previous falls.2. An admission Record indicated the facility admitted Resident #62 on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of unspecified dementia with agitation, anxiety disorder, and repeated falls.A quarterly Minimum Data Set, with an Assessment Reference Date (ARD) of [DATE], revealed Resident #62 had a Brief Mental Status Score (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was independent with ambulation and required supervision or touching assistance during toileting transfers. During an observation on [DATE] at 4:58 PM of the restroom in Resident #62's room, a piece of artwork approximately 18 inches by 24 inches was seen lying on a table inside the restroom door. The observation revealed another piece of artwork on top of it, measuring approximately 12 inches by 12 inches. The glass covering the 18-inch by 24-inch picture was shattered, and some glass was loose. All the broken glass was contained in the frame, and the loose shards were underneath the 12-inch by 12-inch picture. No broken glass was seen on the floor of the resident's restroom, and Resident #62 was not in their room.During an interview on [DATE] at 6:20 PM, Licensed Practical Nurse (LPN) #2 stated that the glass was unsafe and someone could hurt themself. He stated Resident #62 used their restroom and there were wandering residents on the unit that went into other residents' rooms. He stated the resident did not have any physical behaviors that would have caused the broken glass, but they may have knocked it off the wall trying to stabilize themself. He stated maintenance should have been notified, and the picture removed from the restroom. He stated nothing was shared with him during shift report about the broken glass. During an interview on [DATE] at 3:15 PM, Registered Nurse (RN) #7 stated she worked on the unit where Resident #62 resided on [DATE] and did not recall anything memorable happening in the resident's room. She stated there were no loud crashes or reports of broken glass. RN #7 stated that the nurse did not normally go into the resident's room, and the resident was able to communicate their needs to the staff. She stated the resident was able to use the restroom on their own, and the certified nurse aides (CNAs) waited outside the door if the resident needed assistance. Per the RN, if the resident found a broken picture in their restroom, they would have told the staff or brought it to them. She stated that broken glass should be cleaned up immediately to prevent injury to the residents. She stated there were residents that wandered the unit that could get hurt. During an interview on [DATE] at 12:17 PM, Housekeeper (HK) #26 stated that the housekeeper who normally covered the unit where Resident #62 resided was on vacation, and she had been covering the 300 Unit for the past two weeks. HK #26 stated that she helped move Resident #62 into their room in [DATE], and the glass in the picture was intact. She stated she slid the two pictures between the nightstand and the wall in the resident's restroom to minimize the chances of them falling and breaking. HK #26 stated that she saw the broken glass in Resident #62's room on Monday morning ([DATE]) when she was cleaning the restroom. However, she stated she did not tell the nursing staff about the glass and forgot to return to the room to clean it up. She stated that broken glass on the units was dangerous because one of the residents may get cut.During an interview on [DATE] at 1:25 PM, CNA #1 stated she worked with Resident #62 on [DATE], and she had worked with them that day, [DATE]. She stated she knew of no incidents in the resident's room and had not seen any broken glass. She stated she assisted the resident to the restroom on [DATE]; however, she remained outside of the restroom door until the resident was finished because the resident did not like people in the restroom with them. CNA #1 stated that she recalled seeing pictures on the nightstand in the restroom but was unsure when she first saw them there. She stated there were residents on the unit who wandered into other residents' rooms, but they usually avoided the rooms in the common area close to the nurses' station. She stated that if she saw broken glass in a resident's room, she would clean it up because it could be dangerous if touched. She also stated that she encouraged family members to not bring glass into the unit. During an interview on [DATE] at 2:11 PM, LPN #3 stated she was working on the unit where Resident #62 resided on the day shift of [DATE] but stated that she did not enter the resident's restroom. She stated Resident #62 was very (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	steady on their feet and was able to take themself to the restroom but asked for staff assistance. She stated that broken glass was hazardous to the residents on the unit.During an interview on [DATE] at 2:15 PM, the Director of Maintenance (DOM) stated that prior to the evening of [DATE], he had not received a report of broken glass in Resident #62's restroom. He stated the broken glass should have been removed. During an interview on [DATE] at 8:07 AM, the Director of Nursing (DON) stated if the staff saw a broken picture frame in a resident's room, they should call maintenance to look at the broken item and call housekeeping to clean up the glass. She stated there were four residents that wandered on the 300 Unit; however, there had been no injuries caused by potentially broken glass. She stated LPN #2 notified her of the broken glass on Tuesday evening ([DATE]). She stated she spoke with a couple of staff about the frame, and no one knew about the broken glass. During an interview on [DATE] at 9:14 AM, the Executive Director (ED) stated if broken glass was found in resident rooms, housekeeping should be notified to clean it up or the staff member who discovered it should clean it up. She stated she was unaware that HK #26 knew about the broken glass on Monday, [DATE].

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to ensure foods items stored in the walk-in refrigerator and freezer were covered, labeled and dated and expired food items were discarded. The facility further failed to ensure wash dishes as directed by the facility policy. Lastly, the facility failed to ensure hot foods were held on the tray line at a temperature of at least 135 degrees Fahrenheit. These deficient practices had the potential to affect residents who received food from the kitchen. Findings included:1. A policy titled, Food Receiving and Storage, revised 10/2017, indicated, Policy Statement Food shall be received and stored in a manner that complies with safe food handling practices. Per the policy, 8. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date).During a concurrent interview and observation of the walk-in refrigerator with the Dietary Director (DD) on 12/09/2025 at 4:15 PM, the following was noted: - One plastic bottle of horseradish sauce stored after opening did not have a label to record the date opened or the use by date (UBD). The DD stated the horseradish should have a label with the date opened and a UBD.- A plastic bottle of water identified by the DD as belonging to an employee was stored on a shelf. The DD stated employees' food should not be stored in the refrigeration with food for residents.- A 12-ounce plastic container of minced garlic was stored after opening without a label to include the date opened or a UBD.- A 12-ounce container of chocolate syrup was stored after opening without a label to include the date opened or UBD.- Six clear plastic bags of flour tortillas contained 14 tortillas per bag with a manufacturer best by date of 11/04/2025. The DD stated the flour tortillas should have been discarded by the manufacturer best by date.- A container of leftover cooked carrots was stored with no date of storage or UBD.- Three flats of fresh shelled unpasteurized eggs with 24 eggs per flat were stored with one flat stacked on top of the other. The top flat of eggs contained two eggs that were cracked, which exposed the white/yolk that spilled onto the remaining eggs on the top flat. The DD stated the flat with two cracked eggs should have been discarded.- A five-pound box of yellow cake mix was stored opened to air. The DD stated the box should be stored in a closed/sealed container.- A ten-pound box of fresh bell peppers included five bell peppers with dark soft spots and fuzzy hair-like growth, identified as mold by the DD. The DD stated the five bell peppers should be discarded.- Parsley wrapped in plastic wrap was stored without a date of storage or a UBD. The DD stated the parsley should have the date of storage and UBD.- Three stalks of celery stored in a plastic bag were brown, soft, and in a pool of brown-colored liquid. The DD stated the celery had signs of spoilage and should be discarded.- A 25-pound box of fresh tomatoes had 25 tomatoes that were soft/mushy with hair-like growth identified by the DD as mold. The DD stated the 25 tomatoes should be discarded. During a concurrent interview and observation of the freezer with the DD on 12/09/2025 at 4:44 PM, there was a plastic bag that contained 40 frozen omelets and was stored opened to air. The DD stated the bag of omelets was exposed to air, stored without being properly sealed, and should be sealed and dated with a UBD. During an interview on 12/09/2025 at 4:55 PM, the DD stated he expected all dietary staff to label/date foods when they were returned to the walk-in refrigerator. According to the DD, he and the cooks were responsible for monitoring the walk-in refrigerator and freezer for items properly stored. During an interview on 12/11/2025 at 12:55 PM, the Executive Director stated she expected dietary staff to date/label all items stored in refrigeration, monitor cold storage at least each shift to ensure all items were labeled/dated, and remove all expired foods. During an interview on 12/11/2025 at 2:15 PM, the Director of Nursing (DON) stated she expected dietary staff to label/date items with the open date and the date it expired before items were placed in refrigeration. The DON also stated she expected food to be stored covered. 2. A facility policy titled, Dishwashing Machine Use, revised 03/2012, indicated 2. Dishwashing machines that use hot water to sanitize must maintain the following wash solution temperatures: 140 F [degrees Fahrenheit] for stationary rack, dual temperature machines, or (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	multi-tank, conveyor, multi-temperature machines. 3. Dishwashing machine hot water sanitation rinse temperatures may not be more than 194 F, or less than, b. 180 F for all other machines. The policy specified, 7. The operator will check temperatures using the machine gauge with each dishwashing machine cycle and will record the results in a facility approved log. The operator will monitor the gauge frequently during the dishwashing machine cycle. Inadequate temperatures will be reported to the supervisor and corrected immediately. During a concurrent interview and observation of the dish machine in use by Dietary Aide (DA) #10 on 12/09/2025 at 5:02 PM, revealed as DA #10 washed a tray of forks, knives, and spoons, the dish machine registered a wash temperature of 118 degrees F, and the final rinse temperature did not register but indicated Probe Error, Final Rinse. DA #10 stated he did not check the dish machine temperatures before or during the wash cycle. During an interview on 12/09/2025 at 5:10 PM, the Dietary Director (DD) stated the dish machine was a high-temperature machine, and the manufacturer wash cycle temperature should be at least 150 degrees F and the final rinse temperature should be at least 180 degrees F. During a follow-up interview on 12/11/2025 at 12:32 PM, the DD stated he was not aware of the Probe Error on the dish machine as DA #10 did not report any concerns to him regarding the dish machine, but that DA #10 should have reported the Probe Error message to him. The DD stated that he expected staff to check the wash/rinse cycle temperature while the dish machine was in use and report any concerns to him immediately. During an interview on 12/11/2025 at 12:55 PM, the Executive Director (ED) stated she expected dietary staff to monitor the water temperature of the dish machine with each use and report to the supervisor if water temperatures were too low. The ED stated that dietary staff should wash dishes per the facility policy/manufacturer instructions for wash/rinse cycle temperatures and if the temperatures were too low, dietary staff should wash dishes in the 3-compartment sink until the issue was resolved. During an interview on 12/11/2025 at 2:15 PM, the Director of Nursing stated she expected the dietary staff to wash/rinse dishes in the dish machine using water that was hot enough.3. A facility policy titled, Record of Food Temperatures, implemented 10/20/2024, indicated 2. Hot foods will be held at 135 degrees Fahrenheit or greater.During a concurrent interview and observation of lunch tray line on 12/11/2025 at 12:18 PM, the temperature of the pureed green beans was 111 degrees F and the mechanically chopped pork was 127 degrees F to 131 degrees F. [NAME] #11 stated hot foods should be held at a temperature of at least 135 degrees F or higher. [NAME] #11 stated a thermometer was typically kept in the hot holding unit for temperature monitoring, but that unit currently did not have a thermometer. During an interview on 12/11/2025 at 12:48 PM, the Dietary Director (DD) stated hot foods should be held at least 135 degrees F and the thermometer used to monitor the temperature of the hot holding unit was not inside the unit. The DD stated he last saw the thermometer inside the hot holding unit a few days prior. During an interview on 12/11/2025 at 12:55 PM, the Executive Director stated she expected hot foods to be held at the correct hot holding temperature. During an interview on 12/11/2025 at 2:15 PM, the Director of Nursing stated she expected hot foods to be kept hot throughout the tray line to make sure there was no opportunity for bacteria to grow.