STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility beginning September 15, 2019 to September 19, 2019 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census the first day of the survey was 79. For the Emergency Preparedness survey, all contracts, operations plan, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from September 15, 2019 through September 19, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census the first day of the survey was 79. The survey sample size was 38 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; Advance Directive - a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor; CPR - Cardiopulmonary resuscitation, an emergency procedure that is done when	F 000		

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

Electronically Signed | 10/16/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 someone's breathing or heartbeat has stopped in hopes of providing time for first responders to arrive; Diabetes mellitus: more commonly referred to as "diabetes" -- a chronic disease associated with abnormally high levels of the sugar glucose in the blood; DNR - a do-not-resuscitate order, or DNR order, is a medical order written by a doctor. It instructs health care providers not to do cardiopulmonary resuscitation if a patient's breathing stops or if the patient's heart stops beating; DON - Director of Nursing; Edema - retention of fluid into the tissue resulting in swelling; EHR - Electronic Health Record; Full Code - a designation that means to intercede if a patient's heart stops beating or if the patient heart stops breathing; GERD - gastroesophageal reflux disease - occurs when stomach acid or, occasionally, stomach content, flows back into your food pipe; lbs (pounds)- unit of weight; MAR - Medication Administration Record; MDS - Minimum Data Set/standardized assessment tool used in long term care facilities; NHA - Nursing Home Administrator; RN - Registered Nurse; TAR - Treatment Administration Record; Urinary Tract Infection (UTI) - bacteria in urine;	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group,	F 565		11/11/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 2 to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interviews and review of Resident Council Meeting minutes, it was determined that the facility failed to act upon resident grievances concerning staffing, failed to consider the resident council's views regarding policies affecting resident life, and failed to act upon resident group grievances or provide a response to the group regarding those	F 565	A. 1. The Administrative and Religious Life Director, also known as the Grievance Official (GO) met with the Resident Council President on October 10, 2019, to schedule a Resident Council meeting on October 11, 2019, to discuss how the Council would prefer that facility staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 3 grievances. Findings include: Review of the Resident Council Meeting Minutes revealed the following: 12/11/18 - There was discussion regarding call bell response times. Comments were made about having to wait a long time, especially on weekends. 3/12/19 - A resident brought up the issue of call bells not being answered quickly. The bell is answered and the light turned out, however, it takes a long time for someone to come and assist the resident. 6/13/19 - Call bells are not being answered quickly. 9/18/19 at 11:00 AM - During the resident council meeting with 14 residents and the surveyors, in response to the questions: "Does the facility consider the views of the resident or family groups and act promptly upon grievances and recommendations?" The resident group stated that they had been complaining about staffing issues such as call bell wait times and lack of available staff during meal times, but nothing has changed. "Does the Grievance Official respond to the resident or family group's concerns?" The resident group stated that they have continued to bring staffing concerns up at council meetings, but get no response. " If the facility does not respond to concerns, does the Grievance Official provide a rationale for the	F 565	respond to their grievances and recommendations; and, how facility staff can improve their response to resident grievances and recommendations. 2. On October 11, 2019, a special Resident Council meeting was held. The following topics were discussed: call bell response time, staffing of the main dining room and satellite dining room during mealtimes, resident rights related to television and media in their rooms, the Kutz Rehabilitation and Nursing staff member assigned as the GO, and follow-up to the Resident Council on grievances discussed at their meetings. 3. The GO confirmed to the Resident Council President and Resident Council that she was the senior staff member assigned to be the GO for the Council. 4. The GO reviewed the council□s grievances related to call bell response times and elicited their input for acceptable wait times once call bells were activated. The Department of Nursing revised the call bell policy (See attached N-1) approximately 4 weeks ago. Staff have been in- serviced on the new requirements, and the facility□s leadership team is monitoring the plan via daily audits of call bell response times. Council members were asked if they have noticed any improvement in call bell response times in the last 4 weeks, and they unanimously indicated they had. 5. During the October 11, 2019 Resident Council meeting, council members raised concerns about insufficient staffing in the main dining room and satellite dining rooms during mealtimes, especially	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 4 response? The resident group was unsure who the Grievance Official was. "If the resident council makes suggestions about rules does the facility act upon them?" The resident group stated that they had concerns regarding the rule that the televisions have to be turned off at 10:00 PM, but were told it was a rule and they had to abide by it. Some residents stated that at 10:00 PM staff come in and turn their television off, citing this rule. Residents stated this was done regardless of the resident's wish to have the television left on. Review of the facility Television Policy revealed, "Out of consideration for other residents televisions must be turned off by 10:00 PM. However, if the resident would like to have the television on later the resident can acquire a set of headphones." The facility failed to consider the resident group views and act upon grievances and recommendations, and facility staff failed to discuss decisions with the resident group and document in writing their response and rationale. Findings were reviewed with E1 (interim NHA) and E2 (DON) on 9/19/19 at 6:15 PM during the exit conference.	F 565	weekend meals. The DON (Director of Nursing) and ADON (Assistant Director of Nursing) have been assigning additional CNAs (Certified Nurse□s Assistant) to the main dining room and satellite dining rooms for all meals, including weekend lunches and dinners beginning September 25, 2019. (Breakfasts are served by tray to all residents in their rooms). 6. The Television policy has been revised (See attached N-2). The GO informed the Resident Council that all residents and/or their responsible parties will be informed that they have the right to listen to their televisions, radios and/or other media whenever they wish. All residents having roommates have also been asked to be considerate of their roommate□s wishes when listening to their media, especially late at night. A letter to this effect (See attached N-3) has been given or mailed to all residents and or their representatives. The Admissions Director will include this notification in the Admissions Packet for prospective residents and their families. 7. The Resident Council agreed to invite the ED (Executive Director) and facility senior staff to attend Resident Council meetings on an ad hoc basis, so they may address Resident Council member questions, grievances, and recommendations in real time. B. All residents have the potential to be affected by the deficient practice(s) of insufficient staff responses to the grievances and recommendations from their Resident Council, specifically	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 5	F 565	regarding staffing at mealtimes, call bell response times and their right to enjoy media as they wish. As indicated above, facility staff are working with the Resident Council President and Resident Council to ensure adequate, timely responses to Resident Council grievances and recommendations. The DON and ADON will supervise the new call bell policies and procedures; and, will work with the RN Supervisors to ensure that additional CNAs are assigned to cover lunch and dinner meals in the main dining room and satellite dining rooms. C. 1. In order to more effectively consider Resident Council views and act on their grievances and recommendations, facility senior staff (Interim Executive Director (IED), ED, GO, DON, ADON, Social Worker, Foodservice Director, Physical Plant Supervisor, Activities Director, Admissions Director and a representative from the Business Office) will attend Resident Council meetings, as invited by the Resident Council President, to respond to Resident Council member□s grievances and recommendations. In addition, the GO and ED will work with senior staff to prepare a written response to all Resident Council member□s grievances and recommendations from the Resident Council meeting. These written responses will be filed with the Resident Council meeting minutes and will be made available to all residents in a Resident Council loose leaf binder to be kept in the Activities Room library.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 6	F 565	2. The DON and ADON will review staff responses to call bells and CNAs assignments to cover lunch and dinner meals in the dining rooms on a weekly basis. They will submit a monthly report on call bell response times and CNAs mealtime assignments to the ED. 3. The GO□s name, title, and contact information has been posted conspicuously in a public area. 4. The GO or designee will investigate all individual resident and/or family member grievances and will provide written responses to the resident and/or family member with rationales and timetables within one week of the initial complaint. In the GO's absence, residents and/or family members will be directed to the ED who will handle their grievances and provide written responses with rationales and timetables within one week of the initial complaint. All resident and/or family member grievances and written responses will be kept strictly confidential. The GO will inform all residents verbally or in writing of their right to bring any and all grievances to her (or the ED)attention. In addition, the GO informed all family members (or responsible parties) (See attached N 1-a) that they should bring any grievances to her attention. D. The ED and GO will review Resident Council grievances and recommendations (and actions taken to resolve them) at each weekly senior staff meeting (held every Monday at 9:30 am). The ED and GO will submit monthly summaries of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 7	F 565	Resident Council grievances and recommendations (and actions taken to resolve them) to the QAPI (Quality Assurance and Performance Improvement) Committee, at each monthly□s QAPI meetings. The DON and ADON will prepare monthly reports on call bell response times and CNAs assignments to cover meals in the dining rooms for the monthly QAPI Committee meetings. At each monthly Resident Council meeting beginning with the next scheduled Resident Council meeting on November 11, 2019, the Council members will be polled to determine the success of the above initiatives, and any other grievances moving forward. Success will be considered to be at least eighty (80%) percent positive response rate from the members present at four (4) consecutive monthly Resident Council meetings beginning with the next scheduled Resident Council meeting on November 11, 2019.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		11/11/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 8 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy, and interviews, it was determined that for two (R5 and R127) out of 38 sampled residents, the facility failed to ensure that the advanced directives were obtained in a timely manner for one resident (R127) and the facility failed to update the code status for one resident (R5). Findings include:	F 578	A. 1. Past practices cannot be corrected for resident R127. 2. Code status for Resident R5 was updated on 9/17/2019 (See attached N-4) and R127 (See attached N-5). B.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 9 Review of the facility's Advance (sic) Directives Policy, revised January 2017, revealed that part of the procedure for obtaining an advanced directive included: 1. Upon admission, the Admissions Director will...inform the resident of his/her right to make an advanced directive. 2. The Admissions Director will inquire if there is an advanced directive and request a copy for the resident's medical record. 3. The Resuscitation Procedure Form will be presented to the resident or responsible party regardless of advanced directives. The facility's goal is to obtain a signature as soon as possible and have it placed in the resident's medical chart. 4. Resident and/or his/her representative will be informed that without a signature on the resuscitation form, the resident will automatically be treated as a full code. 1. Review of R127's clinical record revealed: 8/27/19 - R127 was admitted to the facility following left hip surgery with diagnoses that included seizures, high blood pressure, pacemaker, and chronic stomach ulcer. 8/27/19 - The Interagency Nursing Communication Record from the hospital listed the code status as DNR (do not resuscitate). 9/16/19 at 11:26 AM - A physician's order was written for DNR, RN may pronounce. 9/16/19 - R127 signed a Resuscitation Decision Form and listed his/her code status as DNR. 9/17/19 at 4:21 PM - During an interview, E7 (Admissions Director) stated he/she asked R127	F 578	All residents□ charts have been reviewed to ensure there is a signed resuscitation decision form and a physician's order for the code status. C. 1. We have revised the advance directive policy (See attached N-6) to now require code status to be discussed on admission and a resuscitation decision form to be signed. 2. Upon readmission, a new code status will be discussed with the resident and or his/her representative and a new resuscitation decision form will be signed either in person or via phone by two nurses. The staff educator or designee will in-service all nurses. D. 1. The DON, or designee, will audit all new residents□ admission and readmission charts to ensure that there is a signed resuscitation decision form with the correlating physician's order for completion weekly x 4 weeks until 100% compliance has been achieved, then monthly x 4 months until 100% compliance is achieved, then quarterly times x 4 quarters until 100% compliance is achieved. 2. The DON or Designee will report results monthly at the monthly QAPI meeting for review, discussion and evaluation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 10 about his/her code status on admission and R127 was unsure what he/she wanted to do. E7 stated that he/she informed nursing staff about this so they could follow up with R127. The facility failed to follow the Advance Directives policy and obtain a signed resuscitation form for R127 until 19 days after admission to the facility, resulting in the possibility that R127's desire that his/her code status be DNR would not be honored. Findings were reviewed with E2 (DON) and E3 (ADON) on 9/18/19 at 10:30 AM. 2. Review of R5's clinical record revealed: 9/16/19 at 10:18 AM - A review of R5's advanced directives revealed that R5 was a "Full Code", effective 3/8/12. 9/17/19 at 4:45 PM - A review of the EHR (Electronic Health Record) revealed that the physician order for R5's Full Code status was discontinued on 5/8/19. There was no evidence of an active physician order of R5's current code status transcribed in the EHR. 9/17/19 at 4:50 PM - During an interview, E6 (RN) explained to the surveyor that R5 was admitted to the hospital on 4/29/19 and did not return to the facility until 5/9/19. E6 further confirmed that R5 remained a Full Code and that the physician order for a Full Code status was not renewed and updated in the EHR.	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 11 9/17/19 at 5:41 PM - A new physician order for Full Code was transcribed in the EHR. 9/19/19 at 2:30 PM - Findings were reviewed with E2 (DON) and E3 (ADON). Findings were reviewed with E1 (interim NHA) and E2 during the Exit Conference at 6:15 PM on 9/19/19.	F 578		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after	F 622		11/11/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 12 admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 13 (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that the facility failed to ensure that appropriate resident information was communicated to the receiving health care provider for 1 (R126) out of 3 sampled residents for hospitalization. The facility failed to send a copy of R126's care plans with goals when R126 was transferred to the hospital on 8/11/19 and 9/5/19. Findings include: Review of R126's records revealed the following: 8/11/19 and 9/5/19 - The facility interagency form indicated that the following documents were sent to the hospital as follows: - Medication Administration Record - Treatment Administration Record - Physician History and Physical - Face Sheet	F 622	A. Past practices cannot be corrected for resident R-126 B. For all the other residents past practices cannot be corrected however all residents have the potential to be affected by the deficient practice of failing to communicate necessary and appropriate resident information to the receiving health care provider (including copies of the resident□s care plans). C. We have revised the facility interagency form (See attached N-7) to now include a requirement for the nurses to include among other documents, the resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 14 - Physician Progress Notes - Recent labs, Chest X-ray - Advanced directive/code status 9/19/19 at 12:06 PM - During an interview, E6 (RN) confirmed that comprehensive care plans with goals were not sent with the resident during the hospital transfers on 8/11/19 and 9/5/19. 9/19/19 at 2:30 PM - Findings were reviewed with E2 (DON) and E3 (ADON). The facility failed to include and communicate the comprehensive care plans with goals to the receiving facility. Findings were reviewed with E1 (interim NHA) and E2 at the Exit Conference at approximately 6:15 PM.	F 622	care plans with goals and interventions upon residents transfer or discharge to another healthcare facility (HCF). The Staff Educator or designee will in service all the nurses. D. 1. The DON or designee will audit for completion the interagency forms to ensure care plans with goals and interventions were sent to the receiving agency upon transfer or discharge weekly x 4 weeks until 100% compliance is achieved, then monthly x 4 months until 100% compliance is achieved, then quarterly x 4 quarters until 100%compliance achieved. 2. The DON or Designee will report results monthly at monthly QAPI meetings for review, discussion and evaluation.	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge	F 661		11/11/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 15 medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for one (R76) out of one (1) community discharge sampled resident, the facility failed to develop R76's discharge summary that included a recapitulation of R76's stay, a final summary of the resident's status and post-discharge plan of care, including discharge instructions. Findings include: Review of R76's clinical record revealed: 4/8/19 - R76 was admitted to the facility. 6/13/19 10:07 AM - A nurses note stated that R76's current goal was to go to (name) assisted living. 6/20/2019 10:12 PM - A nurses note stated the resident was discharged to an assisted living facility. Review of R76's clinical record lacked evidence of a complete discharge summary that included: - a recapitulation of R76's stay at the facility that	F 661	A. Past practice cannot be corrected for resident R-76. B. For all the other residents past practices cannot be corrected. C. We have revised the facility practice for documentation provided upon discharge to home, or transfer to another HCF to include the following: i. Discharge Checklist (see attachment N-8) ii. Transfer/discharge report (see attachment N-9) iii. Therapy Clinical Summaries, if applicable iv. Social Service Discharge Summary (see attachment N-10) v. Plan of Care with Goals (see attachment N-11) vi. Physician Discharge Summary (See	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 16 included, but was not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results; and - a post-discharge plan of care that was developed with the participation of the resident, including any arrangements that have been made for the resident's follow-up care and any post-discharge medical and non-medical services. The facility failed to develop a discharge summary that included a recapitulation of R76's stay, a final summary of the resident's status and post-discharge plan of care, including discharge instructions. 9/19/19 at approximately 6:15 PM - During the exit conference, findings were reviewed with E1 (interim NHA) and E2 (DON).	F 661	attached N-12) to include a recapitulation of the resident□s stay, diagnoses, course of illness/treatment or therapy, pertinent labs, radiology results, and consultation results. vii. History and Physical (if discharged to another HCF) (See attached N-13) viii. Progress Notes (if discharged to another HCF) The newly revised required discharge documentation was reviewed and discussed at the monthly QAPI meeting on 10-11-2019. The Staff Educator or designee will in-service nursing staff on the new required discharge documentation. D. 1. The ED will audit the discharge documentation listed above to ensure that all information was sent to the receiving facility or given to resident/family upon home discharge for 100% of all residents transferred to another facility or discharged to home weekly x 4 weeks until 100% compliance is achieved, then monthly x 4 months until 100% compliance is achieved, then quarterly x 4 quarters until 100% compliance achieved. 2. The ED will report results monthly at monthly QAPI meetings for review, discussion, and evaluation.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		11/11/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 17 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and review of the clinical record, it was determined that the facility failed to ensure that one (R47) out of one (1) resident reviewed for vision and hearing received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. The facility failed to ensure that R47 was offered his/her hearing aide. Findings include: Review of R47's clinical record revealed the following: 1/17/18 - R47 was admitted to the facility for long term care with diagnoses that included a bleed in the brain that resulted in left sided paralysis. 1/17/18 - The Baseline Care Plan and Summary stated R47 had moderate difficulty hearing and had a left hearing aide. The Baseline Care Plan stated to encourage R47 to wear the hearing aide. 1/27/18 - A care plan, last revised on 7/18/19, was developed for R47's communication deficit related to difficulty hearing. The care plan stated, "wears L (left) h/a (hearing aide) (doesn't like to wear)." 7/18/19 - The quarterly MDS assessment stated	F 684	A. For R47 hearing aids were obtained and an order initiated to offer hearing aids daily (see attached N-14). B. We will review all residents MDS assessments and care plans to ensure that any resident care-planed to have hearing aides have them, and an order obtained from the physician C. 1. The Baseline Care Plan assessment form (See attached N-15)) has been revised to include the requirement for the nurse to obtain a physician's order for residents who have hearing aides. 2. The unit manager or designee will utilize the revised Baseline Care Plan assessment in completing resident assessment on admission. If the use of hearing aides is noted, the nurse will obtain the hearing aides from the resident or the resident representative and a physician's order will be initiated. 3. The Staff educator or designee will in-service all nurses on the use of the revised Baseline Care Plan. D.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 18 R47 was moderately impaired for daily decision making skills and had moderate difficulty hearing without a hearing aide. Review of current physician's orders lacked any orders for the use of a hearing aide. Review of the 8/19 and 9/19 MAR and TAR lacked evidence of any placement of a hearing aide for R47. 9/15/19 at 10:56 AM - While conducting an interview with R47, it was noted that the resident had difficulty hearing. When asked if he/she had a hearing aide, R47 stated yes. Observation revealed that there was no hearing aide in place. 9/17/19 at 10:41 AM - R47 was observed seated in a geri chair (recliner chair) in the TV area alcove behind the 400 wing nurse's station with the TV playing. R47 had his/her eyes closed and was observed without a hearing aide. 9/17/19 at 12:22 PM - R47 was observed in the dining area at lunch being assisted by staff. Observation revealed no hearing aide in place. 9/17/19 at 12:40 PM - During an interview, R47 stated that he/she has a hearing aide. When asked why the hearing aide was not in place, R47 stated that someone had to put batteries in it. When asked if he/she wants to wear the hearing aide, he/she stated, "sometimes." 9/18/19 at 8:40 AM - During an interview, E5 (RN) stated that he/she has worked in the facility with R47 for approximately 2 months. E5 stated that there was no hearing aide stored in the medication cart for R47 and she has never seen	F 684	The DON or Designee will audit the Baseline care plans and physician orders for hearing aides to ensure completion weekly x 4 weeks until 100% compliance is achieved, then monthly x 4 months until 100% compliance is achieved, then quarterly x 4 quarters until 100%compliance achieved. 2. The DON or Designee will report results monthly at monthly QAPI meetings for review, discussion and evaluation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 19 him/her with one. Additionally, E5 stated there was no physician's order for a hearing aide for R47. 9/19/19 at approximately 9:30 AM - Findings were reviewed with E2 (DON). E2 stated he/she would look into the issue. 9/19/19 at approximately 1:30 PM - During an interview, E3 (ADON) stated that he/she had spoken with R47's POA (Power of Attorney) and was told that the family believed that R47 had to maintain, apply and remove the hearing aide by himself/herself. The POA stated that they felt R47 was not able to do this, so they took the hearing aide home. As a result, R47 was not offered his/her hearing aide by facility staff. The facility failed to ensure that R47 recived treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. The facility failed to ensure that R47 was offered his/her hearing aide. 9/19/19 at approximately 6:15 PM - Findings were reviewed during the exit conference with E1 (interim NHA) and E2 (DON).	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		11/11/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 20 accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that the resident's environment remained as free of accident hazards as is possible. Findings include: On 9/17/19 at 2:02 PM, an observation was made of an unsecured portable oxygen tank at the nurse's station on the 100-200 Wing. E4 (RN) was interviewed regarding the finding at that time. E4 promptly went and obtained a holder for the oxygen tank. Findings were reviewed during the exit conference on 9/19/19 at approximately 6:15 PM with E1 (interim NHA) and E2 (DON).	F 689	A. A holder for the unsecured oxygen tank was obtained and oxygen tank secured on 9-17-2019. B. Unit managers and supervisors completed safety rounds of the entire facility on 9-17-2019 and ensured all portable oxygen tanks were safely secured in holders. C. 1. Oxygen Administration policy (See attached N-16) has been revised to require the use of oxygen holders at all times while transporting and storing oxygen tanks. 2. Nursing supervisor environmental safety checklist (See attached N-17) has been revised to include checking to ensure all oxygen tanks are in holders at all times. 3. Nursing supervisor will utilize the environmental safety checklist every shift during rounds to ensure all oxygen tanks are in holders at times of rounds. 4. Staff educator or designee will in-service all nursing staff on the revised policy. D. 1. The DON or Designee will audit the nursing supervisor environmental checklist for completion weekly x 4 weeks until 100% compliance is achieved, then monthly x 4 months until 100% compliance is achieved, then quarterly x 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 21	F 689	quarters until 100%compliance achieved. 2. The DON or Designee will report results monthly at monthly QAPI meetings for review, discussion and evaluation.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined that the facility failed to recognize, evaluate, and address a significant weight change for one (R32) out of four sampled residents. Findings include: The facility's policy titled, Weights, Revised 2/2012, stated, "Weight loss or gain of five or	F 692	A. Past practices cannot be corrected for resident R32. B. The dietitian has reviewed all residents weights for significant weight loss and ensured that any residents that required to	11/11/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 22 more pounds since the previous weight measurement will require a re-weigh within 24 hours...Any resident with a weight loss or weight gain of 5% or more in 30 days or 10% or more in 180 days will be assessed by the dietician and results documented." Review of R32's clinical record revealed: 3/16/16- R32 was admitted to the facility. 3/1/16- A care plan was initiated stating that R32 had a nutritional problem related to a past medical history of diabetes mellitus, anxiety, depression, GERD, therapeutic diet, history of weight loss/gain, altered skin integrity, history of UTI, and a history of edema. Interventions included monitoring R32's weights. 2/12/19-8/9/19- Review of R32's weights revealed that on 2/12/19 R32 was 218.6 lbs. On 3/13/19, R32's weight was 218.4 lbs. On 4/1/19, R32's weight was 219.0 lbs. On 7/8/19, R32's weight was 203.7 lbs. On 8/9/19, R32's weight was 198.2 lbs, which was a weight loss of 5.7 lbs in one month and a total of 9.5% weight loss in six months. There was no evidence that a re-weight was done within 24 hours of 8/9/19 per facility policy. 8/22/19 10:31 AM- A nutrition progress note was written documenting an assessment of R32's nutritional status. This was 13 days after R32 lost more weight on 8/9/19. There was no evidence that R32's nutritional status was assessed prior to this date. 9/4/19- Review of R32's weights revealed that he/she had lost more weight and was now 189.2	F 692	be re-weighed were done and followed up with accordingly. C. 1. A new weight tracking tool (See attached N-18) has been developed to capture previous weights for comparison to the current weights being obtained. 2. The CNA or designee will utilize the weights tracking tool while obtaining weights for comparison to previous weights. Any weight loss or gain of 5 pounds or more since the previous weight will require a reweigh within 24 hours and accurately documented. 3. The dietitian will review weekly, the weights tracking tool and address any noted weight loss or gain of five pounds or more. 4. The staff educator or designee will in-service all nursing staff and the dietitian on the utilization of the new weights tracking tool. D. 1. The DON or designee will audit the weights tracking tool for timely completion weekly x 4 weeks until 100% compliance is achieved, then monthly x 4 months until 100% compliance is achieved, then quarterly x 4 quarters until 100%compliance achieved. 2. The DON or Designee will report results monthly at monthly QAPI meetings for review, discussion and evaluation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 23 lbs. This was a weight loss of 9 lbs in one month and a significant weight change of 13.61% within six months. There was no evidence that a re-weight was done within 24 hours per facility policy. 9/12/19 10:31 AM- A nutrition progress note was written documenting an assessment of R32's nutritional status. This was 8 days after R32 lost more weight on 9/4/19. There was no evidence that R32's nutritional status was assessed prior to this date. 9/16/19- R32 was not re-weighed until this date and it was documented that his/her weight was 189.0 lbs. 9/18/19 1:54 PM- During an interview, weights and nutritional assessments were reviewed and confirmed with E8 (Dietician). The facility failed to recognize, evaluate, and address R32's significant weight change per facility policy. 9/19/19 at approximately 6:15 PM- Findings were reviewed during the exit conference with E1 (interim NHA) and E2 (DON).	F 692		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758		11/11/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 24 (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 25 the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that medication regimens were free from unnecessary psychotropic medications for two (R48 and R71) out of five sampled residents. For both residents, the facility failed to accurately monitor behaviors for psychotropic medications. Findings include: 1. The following was reviewed in R48's clinical record: 10/11/18 - R48 was admitted to the facility with diagnoses that included, psychotic disorder with delusions, major depressive disorder, anxiety, and dementia without behavioral disturbance. 10/18/18 - A care plan for R48 was initiated with a focus that R48 had mood and behaviors related to depression, anxiety and psychosis. Interventions included medications as ordered, monitor for side effects and effectiveness, and monitor and document mood and behaviors. 4/16/19 - A consent form for Zyprexa, an antipsychotic medication, was signed by R48's representative. The targeted behaviors for this medication were delusions. 9/18/19 - Review of R48's Behavior Intervention Monthly Flow Record for August 2019 and September 2019 revealed that for the antipsychotic medication Zyprexa, R48 was being monitored for yelling and verbalization of feeling depressed. 2. The following was reviewed in R71's clinical	F 758	A. For resident R48 past practices cannot be correct as resident no longer is in the facility and resident R71 Behaviors Interventions Monthly Flow Record (See attached N-19) behaviors to be monitored for related to the use of Zyprexa antipsychotic medication were corrected on their individual Behavior Interventions Monthly Flow Records to reflect accurately as care planned. B. For all residents on psychoactive medications, Behavior Interventions Monthly Flow Records were reviewed to ensure that the behaviors being monitored reflects accurately as care planned. C. 1. The new orders verification form has been revised to now require the nurse who is reviewing new psychoactive medications ensures that the behaviors being monitored for the use of psychoactive medications are accurately recorded on the Behavior Interventions Monthly Flow Record as per the resident's care plan. 2. The staff educator or Designee will in-service all nurses on the use of the revised New Medication Order Form. D. 1. The ADON or designee will audit the Behavior Intervention Monthly Flow	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 26 record: 12/3/14 - R71 was admitted to the facility with diagnoses that included, unspecified psychosis, major depressive disorder, anxiety, and dementia without behavioral disturbance. 8/26/19 - A care plan for R71 was revised with a focus that R71 had mood and behaviors secondary to psychosis with hallucination. Interventions included medications as ordered, monitor for side effects and effectiveness, and monitor and document mood and behaviors. 2/25/19 - A consent form for Zyprexa, an antipsychotic medication, was signed by R71's representative. The targeted behaviors for this medication were delusions, crying, agitation, and refusing care. 9/18/19 - Review of R71's Behavior Intervention Monthly Flow Record for August 2019 and September 2019 revealed that for the antipsychotic medication Zyprexa, R71 was being monitored for tearfulness and little interest in doing things. Findings were confirmed with E2 (DON) on 9/19/19 at 10:30 AM. The facility failed to provide evidence of adequately monitoring the behaviors associated with the use of antipsychotic medication. Findings were reveiwed with E1 (interim NHA) and E2 (DON) during the exit conference on 9/19/19 at 6:15 PM.	F 758	Records for accuracy weekly x 4 weeks until 100% compliance is achieved, then monthly x 4 months until 100% compliance is achieved, then quarterly x 4 quarters until 100%compliance achieved. 2. The ADON or Designee will report results monthly at monthly QAPI meetings for review, discussion and evaluation.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Kutz Rehabilitation and Nursing **DATE SURVEY COMPLETED: September 19, 2019**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint and emergency preparedness survey was conducted at this facility from September 15, 2019 through September 19, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census the first day of the survey was 79. The survey sample size was 38 residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey completed September 19, 2019: F565, F578, F622, F661, F684, F689, F692 and F758.	Cross refer to F565, F578, F622, F661, F684 F692, F689, F758	11/11/19

Provider's Signature John S. Oppenheimer, NHA Title Interim Executive Director Date Oct 6 2019 10-18-19

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Kutz Rehabilitation and Nursing **DATE SURVEY COMPLETED: September 19, 2019**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE

Provider's Signature [signature] Title Interim Executive Director Date 10-16-2019