DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long-Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: KUTZ Rehabilitation and Nursing   **DATE SURVEY COMPLETED:** March 4, 2026

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 survey was conducted at this facility from February 24, 2026, through March 4, 2026. The deficiencies contained in this report are based on observations, interviews, review of the residents' clinical records and review of other facility documents as indicated. The facility census on the first day was (sixty-eight) 68. The sample size totaled (nineteen) 19 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 was not met as evidenced by: Cross Refer to the CMS 2567 – L survey completed March 4, 2026: cross refer: F600, F609, F677, F689 and F730.		

Provider's Signature Title LNHA, CEO Date 3/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085043	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	**704 RIVER ROAD , WILMINGTON, Delaware, 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
E0000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility from February 24, 2026 through March 4, 2026. The facility census was sixty-eight (68) on the first day of the survey. In accordance with 42 CFR 483.73, an emergency preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		03/23/2026
F0000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from February 24, 2026 through March 4, 2026. The deficiencies contained in this report are based on observations, interviews, review of the residents' clinical records and review of other facility documents as indicated. The facility census on the first day of the survey was 68. Abbreviations/definitions used in this report are as follows: Activities of Daily Living (ADLs) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; ADON - Assistant Director of Nursing; BIMS (Brief Interview for Mental Status) - assessment of the resident's mental status. The total possible BIMS Score ranges from 0-15 with 15 being the best. 0-7 - Severe impairment (never/rarely made decisions) 8-12 - Moderately impaired (decisions poor; cues/supervision required) 13-15 - Cognitively intact (decisions consistent/reasonable); CNA - Certified Nursing Assistant;	F0000		03/23/2026

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 reverse for further 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **085043**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/04/2026**

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F0000	Continued from page 1 Dialysis - cleansing of the blood by artificial means when the kidneys have failed; DON - Director of Nursing; End-Stage Renal Disease - a disease where the kidneys stop working; Incontinence - loss of control of bladder &/or bowel function; LPN - Licensed Practical Nurse; LSW - licensed Social Worker; MDS assessment - federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; NHA - Nursing Home Administrator; RN - Registered Nurse; RNAC - Registered Nursing Assessment Coordinator; SSD - Social Services Director.	F0000		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of other	F0600	"Past Noncompliance - no plan of correction required"	03/23/2026

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F0600 SS = D	Continued from page 2 facility documents, it was determined for one (R10) out of three residents reviewed for abuse, the facility failed to ensure that R10 was free from verbal abuse from a staff member. Findings included: 12/2017 – A facility document entitled, Resident Abuse Prevention, Protection, Identification, Suspected Crime, Incident Reporting and Investigation Policies and Procedures, revised 12/2022, 12/2023, 3/2024, 3/2025, and 5/2025 included, "The facility will prohibit, prevent and not tolerate residents to be subjected to abuse….by anyone, including staff members…" R10's clinical record revealed: 1/10/25 – R10 was admitted to the facility with diagnoses, including but not limited to, cancer of the rectum. 7/15/25 – R10's quarterly MDS assessment documented a BIMS score of 15, indicating a fully intact cognitive status. R10's MDS also documented that he was independent for ambulation with a rolling walker. 9/10/25 5:54 PM – A facility reported incident submitted to the State Survey Agency documented, "Resident [R10] reported to [E6] (SSD) that on 8/22/25 during the 11 PM to 7 AM shift he went outside off campus to smoke and when he returned to the facility and started walking toward the [unit number] nursing station and he had an encounter with [E7] (RN.) Per R10, E7 stated, "[R10] when I am here on the night shift, you are not allowed to [expletive] go outside." E10 reported that he replied, "I don't know who the [expletive] you are talking to, but you can't talk to me like a piece of [expletive.]" R7 replied, "If you go out that door, I am telling the staff not to buzz you back in." 9/16/25 – The facility's 5-day follow up report submitted to the State Survey Agency documented that based on the facility's investigation and review of video camera recording the allegation of verbal was substantiated and E7 was terminated. 2/26/26 9:00 AM – During a telephone interview, E9 (CNA) stated, "The nurse [E7] was upset that night because she was called to come into work. I saw and heard her talking to the resident [R10] loudly about his smoking. She also used curse words at him when he answered her back." The Surveyor asked E9 why this incident was not reported to the facility's administration right away. E9 stated, "It was during	F0600		

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F0600 SS = D	Continued from page 3 the night shift and she [E7] was the supervisor." 2/26/26 9:30 AM – During a telephone interview, E8 (RN) stated, "I saw the nurse talking to the resident, but I was too far away to hear what they were saying. 2/26/26 10:00 AM – During a telephone interview, E7 stated, "I was the on-call nurse, and I was called to come into work. I spoke to the resident about going out to smoke, but I don't recall cursing at him." 2/26/26 11:00 AM – During an interview, the Surveyor asked E1 (NHA) about why the incident report was submitted to the State Agency on 9/10/26 when the resident reported the incident on 8/23/25. E1 stated, "We thought it was more like a grievance and were investigating it that way. When we realized that it was actually a reportable incident, we reported it right away." 2/26/26 1:30 PM – The facility provided the Surveyor with abuse prevention and resident protection education that was provided to the staff. During a combined interview, E14 (CNA), E15 (LPN), E17 (CNA), E20 (CNA) and E21 (CNA) confirmed that they received education and training on abuse prevention. Based on review of the facility corrective actions, interview with staff members and no further episodes of abuse, this deficient practice is considered past non-compliance with a correction date of 9/12/25. 2/26/26 2:00 PM – Findings were confirmed with E1 and E2 (DON.) 3/4/26 3:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F0600		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that	F0609	1. The allegation of verbal abuse involving Resident R10 was reported to the State Survey Agency on 9/10/25 once the facility determined that the incident met the criteria for a reportable abuse allegation. The facility conducted a thorough investigation. The staff member involved was terminated per policy. The resident voiced no additional concerns related to the incident. 2. All residents residing in the facility with staff complaints have the potential to be affected by this practice. The Administrator conducted a review on March 13, 2026, of all grievances and complaints for the previous 30 days to determine whether any other resident complaints involving staff conduct may have been misclassified and should have been reported as abuse allegations. No	04/21/2026

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F0609 SS = D	Continued from page 4 cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of other facility documents, it was determined for one (R10) out of three residents reviewed for abuse, the facility failed to ensure that the allegation of verbal abuse from a staff member was reported to the State Survey Agency within the required time. Findings included: 9/10/25 5:54 PM – A facility reported incident submitted to the State Survey Agency documented, "Resident [R10] reported to [E6] SSD (Social Services Director) that on 8/22/25 during the 11 PM to 7 AM shift he went outside off campus to smoke and when he returned to the facility and started walking toward the [unit number] unit's nursing station and he had an encounter with [E7] (RN.) "Per R10, E7 stated, "[R10] when I am here on the night shift, you are not allowed to [expletive] go outside." E10 reported that he replied, "I don't know who the [expletive] you are talking to, but you can't talk to me like a piece of [expletive.]" R7 replied, "If you go out that door, I am telling the staff not to buzz you back in." 2/26/26 11:00 AM – During an interview, the Surveyor asked E1 about why the incident report was submitted to the State Survey Agency on 9/10/26 when the resident reported the incident on 8/23/25. E1 stated, "We thought it was more like a grievance and was investigating it that way. When we realized that it was actually a reportable incident and we reported it right away". The facility failed to report the allegation of verbal abuse with the 2-hour reporting requirement. 2/26/26 2:20 PM – Findings were confirmed with E1 (NHA)	F0609	Continued from page 4 additional incidents were identified that required reporting to the State Survey Agency. 3. Root Cause Analysis (RCA): The facility conducted a Root Cause Analysis and determined that the delayed reporting occurred because the resident complaint involving staff conduct was initially classified as a grievance rather than a potential abuse allegation. The employee committing the alleged abuse and the 2nd Unit Manager present during the incident corroborated that the resident was not telling the truth and the alleged abuse did not happen. In addition, staff initially provided inaccurate information during the early stages of the investigation, which contributed to the misclassification of the complaint. The facility determined there was no structured screening process to ensure that resident complaints involving staff conduct were evaluated as potential abuse allegations prior to classification as grievances. The facility implemented a Staff Interaction Toward Resident Screening Tool to ensure that all complaints involving staff behavior toward residents are screened for potential abuse allegations prior to classification as a grievance. Any complaint involving staff interaction toward a resident must be reviewed as a potential abuse allegation and reported immediately according to facility policy and state requirements prior to initiation of the investigation. Staff Developer (or designee) will educate staff on the Staff Interaction Toward Resident Screening Tool including the requirement that allegations of abuse must be reported immediately and investigated afterward and reinforcing that providing inaccurate or incomplete information during an investigation may result in disciplinary action. 4. NHA (or designee) will conduct audits of all resident complaints regarding staff interactions toward residents daily x 3 to ensure that allegations of abuse are reported immediately until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

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F0609 SS = D	Continued from page 5 and E2 (DON.) 3/4/26 3:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F0609		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on interview and record reviews, it was determined that for two (R16 and R79) out of six residents reviewed for ADLs (Activities of Daily Living), the facility failed to ensure each dependent resident received the necessary services to maintain grooming and personal hygiene. For R16, the facility failed to provide incontinence care during the evening shift when her clothes and linens were found saturated with urine. For R79, the facility failed to ensure that R79's morning care was done when he was found wearing his pajamas in the afternoon. Findings include: 1. Review of R16's clinical record revealed:6/19/24 - R16 was admitted to the facility with diagnoses including dementia. 7/24/24 - R16 was care planned for impaired thought processes related to dementia. 10/30/24 - R16 was care planned for ADL self-care performance deficit related to osteoarthritis and dementia with interventions including partial to substantial assistance of one person for personal and oral care and scheduled toileting every 2 hours. R16 required one staff person for toileting and required partial assistance of one person staff to move between surfaces and as necessary. 8/6/25 - A quarterly MDS (Minimum Data Set) assessment revealed that R16's cognition was moderately impaired with a BIMS score of 9. R16 dependent with toileting and required substantial/maximal assist with personal hygiene and upper and lower body dressing. R16 who required partial, moderate assistance with toilet transfer was frequently incontinent of bowel and bladder. 8/19/25 - R16's August 2025 CNA (Certified Nurse	F0677	1. Residents R16 and R79 were immediately assessed and provided the necessary hygiene and personal care after the concerns were identified. Staff ensured that the residents were cleaned, changed, and made comfortable. Skin assessments were completed to ensure no adverse outcomes occurred. The facility conducted an investigation of the incidents. Staff involved in the events were removed from employment following the investigation. 2. Unable to correct in the past and no similar incident have been reported. 3. A Root Cause Analysis (RCA) determined the primary cause of the deficient practice was the absence of a formal supervisory process to verify completion of CNA provided ADL care. Without routine nursing rounds, missed or delayed care was not identified. Contributing factors included CNA failure to notify the nurse when residents are resistant to care and the licensed nurse not ensuring CNA care was completed as care planned. The facility implemented a process requiring nursing supervisors/unit managers to conduct routine rounds each shift to verify residents requiring ADL assistance are clean, dry, appropriately dressed, and that care has been completed according to the care plan. If care has not been provided, immediate missing care will be provided and then immediate remediation of the staff member will occur and the disciplinary process will be initiated per policy. Nursing Supervisors/Unit Managers will document completion on their Supervisor shift checklist. Staff Developer (or designee) will provide education to nursing staff regarding verification of ADL care and consequences leading to the disciplinary process should care not be provided as care planned. 4. The Director of Nursing (or designee) will conduct audits of residents who require extensive assistance or greater with grooming and personal hygiene and who have BIMS less than 12 daily x 3 to ensure that care is delivered timely until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3	04/21/2026

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F0677 SS = D	Continued from page 6 Assistant) Documentation Survey Report revealed that on 8/19/25 during the 3-11 shift, E14 (CNA), the assigned CNA for R16 documented "N/A" or "Not Applicable" for R16's toileting schedule for 3-11 shift at 4:00 PM, 6:00 PM, 8:00 PM and 10:00 PM. 8/19/25 - A facility incident report submitted to the state agency revealed that E14 failed to provide incontinence care to R16 on the 3-11 shift. 8/22/25 - A Facility 5-day follow up summary report documented, "[R16's] clothing and linen was observed by oncoming 11-7 am shift saturated with urine. E28 [LPN] from 3-11 pm shift confirmed findings when notified. CNA [E14] responsible for the for 3-11 pm care of [R16] states [R16] was resistant to care assist during shift, however E28 [LPN] nor E27 [RN] were notified to possibly provide assistance or documentation. Resident care was provided by oncoming shift CNA [E9]. Unable to prove resident care was given during shift to combat allegation... " 3/3/25 1:48 PM - In a telephone interview, E9 confirmed and stated, "I went to do my rounds and saw [R16's] clothing and linen saturated and soaked with urine. Her bed mattress was also wet. I cleaned and changed [R16] and I also cleaned and wiped her bed. I notified the nurse of the incident." 3/3/26 3:00 PM - Finding was discussed with E2 (DON). 2. Review of R79's clinical record revealed: 6/18/25 – R79 was admitted to the facility with diagnoses including dementia, stroke and weakness. 6/27/25 – An admission MDS (Minimum Data Sheet) assessment revealed that R79's cognition was moderately impaired with a BIMS score of 11. R79 required setup or clean – up assistance with eating, partial/moderate assistance with oral hygiene and upper body dressing. R79 required substantial/maximal assistance with toileting, shower/bathing, lower body dressing and personal hygiene. 6/27/25 (revised 7/23/25) – R79's was care planned for ADL self – care deficit and interventions included but not limited to partial assistance by one staff person for dressing, partial to substantial assistance with personal hygiene and oral care and substantial assistance for toileting. 8/4/25 3:11 PM – A facility incident report submitted to the state agency documented that R79's daughter in law [FM1] approached E22 (LSW) because [FM1] did not	F0677	Continued from page 6 months to ensure compliance is obtained and maintained.	

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F0677 SS = D	Continued from page 7 believe [R79] had received morning care. [R79] was still in his pajamas in bed when [FM1] arrived and [R79] had yet to receive his lunch tray. 8/4/25 – A written statement by E16 (CNA) documented that between 8:30 AM and 9:30 AM R79 was eating breakfast. At 10:00 AM, E16 found R79 asleep in bed. At 12:55 PM, E26 (RN Sup) paged E16 and questioned if E16 had missed or had performed care on R79. 8/4/25 2:59 PM – R79's August 2025 CNA (Certified Nurse Assistant) Documentation Survey Report revealed that on 8/4/25 on the 7-3 shift, R79's dressing task was marked "completed" by E16. 8/11/25 – A facility follow up summary documented that R79 was assigned to E16 during the 7-3 shift on 8/4/25. E16 confirmed that care was not provided to R79 prior to E26 questioning her. 3/3/26 9:48 AM – In an interview, E22 stated that FM1 came to see her around 3:00 PM on 8/4/25 to report that R79's morning care was not done as he was still wearing his pajamas. She also confirmed that "... Only after the family reported to me, and I notified the nurse, then the CNA changed [R79]." 3/3/26 1:55 PM - During a telephone interview, E16 confirmed that she was only able to change and provide care to R79 in the afternoon after she was called by E26. 3/3/26 3:35 PM – Finding was discussed with E2 (DON). 3/4/26 3:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F0677		
F0689 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 accidents. This REQUIREMENT is NOT MET as evidenced by:	F0689	1. Resident R81 was immediately assessed following the fall and transferred to the emergency department for evaluation. Upon return to the facility, the resident was assessed by nursing staff and appropriate monitoring, including neurological checks, was implemented. The resident's care plan was updated to ensure the resident's transfer and bed mobility assistance requirements require a two-person assistance. Staff were re-educated regarding the resident's care needs and safe bed mobility techniques. 2. All residents have the potential to be affected by this deficient practice. All residents' transfer and bed mobility assistance levels were posted inside resident closet doors, consistent with their care plans, by March 13, 2026.	04/21/2026

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F0689 SS = D	Continued from page 8 Based on interview and record review, it was determined for one (R81) out of three residents reviewed for accidents, the facility failed to ensure that R81 received adequate supervision and assistance to prevent accidents to the extent possible. Findings include: 3/17 - A facility document entitled, "Falls", revised 2/25 and 3/25, included, "To institute individualized practices to minimize the resident's risk of falling and to maximize safety from falls..."High Risk" - a Fall Risk Evaluation score of 6 or greater." R81's clinical record revealed: 1/17/18 - R81 was admitted to the facility with diagnoses including, but not limited, to left side weakness after a stroke. 2/6/18 - R81's care plan for bed mobility included, "Extensive - total dependence, support of two persons." 5/26/25 - R81's fall risk evaluation documented a score of 10, indicating a high fall risk. 5/28/25 - R81's quarterly MDS assessment documented a BIMS score which indicated an inability to participate in a cognitive assessment. The MDS also documented that R81 was completely dependent on the staff for all activities of daily living. 8/22/25 8:30 PM - A facility reported incident report submitted to the Division included, "At 1730 [5:30 PM] during peri care from his aid, the resident was turned on to his side and fell from the bed to the floor. The resident suffered head trauma and is on blood thinners...the resident was sent to the ER [Emergency Room] for evaluation..." 8/23/26 4:00 AM – R81 returned to the facility from the ER. The ER report included, "…A small laceration on the top of your scalp, this has been fixed by tying a knot with your hair to bring the edges of the laceration together and securing it with some glue…" 2/26/26 10:00 AM - The Surveyor attempted to call the staff member who took care of the resident when the fall occurred. The phone call was not answered. During an interview, E1 (NHA) stated that education on safe patient handling was provided to the aide. The Surveyor asked education was provided to other staff member. E1 stated, "No." 2/26/26 11:10 AM – A review of the facility's	F0689	Continued from page 8 3. A Root Cause Analysis (RCA) was conducted which determined that the facility did not have an effective system to ensure staff had immediate access to accurate bed mobility assistance requirements at the point of care. Resident bed mobility assistance requirements were documented within the electronic care plan; which was not readily accessible to staff during the provision of care. The resident's care plan contained inconsistent documentation regarding the required level of assistance, which contributed to confusion regarding the appropriate level of staff assistance. The facility implemented the following system changes: • A process to post bed mobility assistance requirements, along with the already posted transfer status, inside resident closet doors to ensure staff have immediate access to assistance levels at the point of care. • Care plans for residents requiring two-person assistance for bed mobility were reviewed to ensure documentation is clear and consistent. • The admission process was updated to ensure bed mobility assistance status, along with the already posted transfer status, is placed in the resident closet at the time of admission. Staff Developer (or designee) will educate Nursing staff regarding verification of resident bed mobility assistance requirements and safe bed mobility techniques, prior to providing care. 4. The Director of Nursing (or designee) will conduct audits of residents requiring two-person assistance for bed mobility daily x 3 to ensure that assistance levels are posted inside resident closet doors and consistent with the care plan until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085043	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0689 SS = D	Continued from page 9 corrective action after the fall revealed that the staff member who provided care for R81 during the fall received education on fall prevention. The facility lacked evidence that timely education for other staff members who provide care was provided. 2/26/26 2:20 PM – Findings were confirmed with E1 (NHA) and E2 (DON.) 3/4/26 3:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F0689		
F0730 SS = E	Nurse Aide Perform Review – 12Hr/Year In service CFR(s): §483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that a performance review was completed at least every twelve months for five (E17, E18, E19, E20 and E21) out of five sampled employees. Findings include: 3/3/26 1:38 PM - Review of the following staff performance evaluations revealed a lack of evidence of a performance evaluation for the past year and was confirmed by E24 (former DON): 1. E17 (CNA) had a hire date of 10/29/24. 2. E18 (CNA) had a hire date of 3/3/20. 3. E19 (CNA) had a hire date of 3/26/15. 4. E20 (CNA) had a hire date of 6/29/23. 5. E21 (CNA) had a hire date of 1/20/12. 3/3/26 3:10 PM - Findings were discussed with E2 (DON). 3/4/26 3:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F0730	F730– Nurse Aide Performance Review Unable to be completed in the past. Performance reviews will be completed for all identified certified nursing assistants by the DON (or designee) by March 31, 2026. All certified nursing assistants have the potential to be affected by this deficient practice. The DON completed an audit which found there were no performance reviews completed for the last fiscal year. All current certified nursing assistants will have performance reviews completed by April 21, 2026. RCA – The Human Resources (HR) Director was on an extended leave of absence at the time performance reviews were to be completed for FY25. The DON stated she was unaware of the annual component of the CNA performance review regulation, and because no raises were issued for FY26 she did not think they needed to be done. For the last 5 years, all employees were made aware that annual reviews will occur in the spring of each year, not on their anniversary hire date, with the expectation that each employee completes a self-evaluation prior to the manager (or designee) completing their evaluation. This practice will continue during new hire orientation, and during the yearly skills fair. There was not a system in place to ensure annual performance reviews for CNA staff occurred. The new HR Manager will add the yearly performance reviews to their CNA tracking process that is already in place. The NHA educated the current DON and HR Manager on the regulation.	04/21/2026

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F0730 SS = E		F0730	Continued from page 10 The HR Manager will audit Certified Nursing Assistants HR records monthly for 3 months to ensure a performance review was completed, until 100% compliance is achieved. All results will be shared with the Quality Assurance committee.	