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:** June 2, 2025

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 Follow-up Survey to the Annual, Complaint Survey ending on March 26, 2025, was conducted by the State of Delaware Division of Heath Care Quality, Office of Long-Term Care Residents Protection on May 28,2025 through June 2, 2025. The facility census on the first day of the survey was seventy-nine (79). The sample size was nineteen (19) residents. The facility was found to not be in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care as of June 2, 2025.		
3201	**Regulations for Skilled and Intermediate Care Facilities**	Cross Reference CMS 2567.	
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.** **These requirements were not met as evidenced by:**		

Provider's Signature Felisha E. Hall Title CEO, LNHA Date 06/19/2025

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	Cross Refer to the CMS 2567-L survey completed June 2, 2025: F684, F688, F700, F755 and F760.		

Provider's Signature Tiliska L. Abel Title CEO, LNHA Date 06/19/2025

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 _____	R-C 06/02/2025

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	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Follow-up Survey to the Annual, Complaint Survey ending on March 26, 2025 was conducted by the State of Delaware Division of Heath Care Quality, Office of Long Term Care Residents Protection on May 28,2025 through June 2, 2025. The facility census on the first day of the survey was seventy-nine (79). The sample size was nineteen (19) residents. The facility was found to not be in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care as of June 2, 2025. Abbreviations/definitions used in this report are as follows: CNA - Certified Nurse's Aide; DON - Director of Nursing; MD - Medical Doctor; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RN - Registered Nurse; MAR - Medication Administration Record;	{F 000}		
{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 facility residents. Based on the comprehensive	{F 684}		6/19/25

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

Electronically Signed | 06/19/2025

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

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{F 684}	Continued From page 1 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 interview and record review it was determined that for one (R23) out of nineteen (19) residents reviewed in the investigative sample, the facility failed to follow a physician's order and failed to ensure that R23's most recent hospice plan of care included the updated changes implemented by the facility. Findings include: 1a. Review of R23's clinical record revealed: 9/19/24 - R23 was admitted to the facility. 4/14/25 2:40 PM - A physician's order was written for olodaterol HCL inhalation aerosol solution adminster two puffs inhale orally one time of a day for COPD (respiratory disorder). 5/2025 - A review of the May MAR documented that R23 did not receive the scheduled dose of olodaterol HCL inhalation on 5/31/25 at 9:00 AM. 5/31/25 10:21 AM - A nursing progress noted documented that olodaterol HCL inhalation aerosol solution was not available and on order. 6/2025 - A review of the June MAR documented that R23 did not receive the scheduled dose of olodaterol HCL inhalation on 6/1/25 at 9:00 AM. 6/1/25 10:10 AM - A nursing progress noted documented that olodaterol HCL inhalation	{F 684}	1.a. & b. Unable to correct in the past. 2.a. All residents on hospice service with inhaler orders have potential to be affected. Residents on Hospice were audited by DON by 6/9/25 to ensure all hospice residents received their inhaler medications as ordered. 2.b. All residents on hospice service have potential to be affected. Residents on Hospice were audited by DON by 6/9/25 to ensure Hospice care plan r/t medications and diet are correct. 3.a. RCA: The licensed nurse was unable to locate the inhaler to provide the medication as ordered in the EMR and Hospice Care Plan. A review of the medication carts was done to determine why the medication was not located. All inhalers are stored in the 3rd medication drawer from the top of the cart, but their location in the drawer was different on all 6 medication carts. All orally inhaled medications, including MDI inhalers and nebulizer medications, will be stored in the first section on the left in the 3rd drawer of each of the six (6)	

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{F 684}	Continued From page 2 aerosol solution was not available and on order. 6/2/25 1:35 PM - During an interview, E5 (LPN) confirmed that the medication actually had been available and in the medication cart. E5 confirmed that the aforementioned medication was documented as not given on the MAR and note was written in the progress notes. The facility failed to follow a physician's order when R23 did not receive two doses of olodateral HCL inhalation solution. 1b. Review of R23's clinical record revealed: 9/19/24 - R23 was admitted to the facility. 4/14/25 - R23 was admitted to the Hospice. 5/14/25 7:00 PM - A physician's order was written for lorazepam intensol concentrate (liquid anti-anxiety medication) give 0.25 mL by mouth every four hours as needed for anxiety and restlessness. 5/14/25 7:02 PM - A nursing progress note documented that "[R23] was very anxious and restless since 3:00 PM, [R23] attempted to be put back into bed from w/c (wheelchair) and [R23] was found attempting to get out of bed on his own... Daughter notified and agreed to labwork and an anti-anxiety medication at this time. Hospice notified, nurse to come out for eval STAT (immediately). Physician notified and new order for CBC (complete blood panel), UA (urinalysis), C&S (culture sensitivity) and Ativan 0.25 mL every four hours as needed. Orders placed and relayed to Hospice."	{F 684}	medication carts. The section will be labelled "Orally Inhaled Meds", and each resident's orally inhaled medications will be separated by a divider indicating the resident's room number. The Staff Development nurse, or designee, will educate all professional nursing staff on the new standardized location and separation of orally inhaled medications. 3.b. RCA: Hospice providers only update their Care Plans every two weeks. Hospice nurses from each provider, along with their clinical liaison, were educated by the DON after the 2025 Annual survey on the new process for acknowledging and confirming changes made by the facility's attending physician and to the Hospice Care Plan. The new process included a paper "Progress Note Form" that was utilized in the resident's Hospice binder for all proposed order changes. There is a section for the facility's attending physician, the Facility's Unit Manager/Supervisor, and the Hospice Representative's signatures, with the date and time it was signed, in each Hospice binder. When both the Facility's attending physician and the Hospice agreed to the order, the licensed nurse input the order and was to write a progress note in the EMR. This was to serve as evidence that the Hospice knew and agreed to the medication/order change between their nursing visits and Order updates in the Hospice binder until the plan of care was updated in the	

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{F 684}	Continued From page 3 5/14/25 3:00 PM - 11:00 PM - A hospice care provider form documented that R23 had recommendations for Ativan Liquid 0.25 mL every four hours PRN orally and a CBC, UA, C&S to rule out UTI. The form lacked evidence that the hospice provider signed for awknowledgement of the aforementioned recommendations. 5/16/25 untimed - A hospice care provider form documented that R23 had recommendations for Ativan Liquid 0.25 mL every four hours PRN orally and Morphine 5 mg every four hours PRN orally. The form lacked evidence that the hospice provider signed for awknowledgement of the aforementioned recommendations. 5/16/25 10:45 AM - A physician's order was written for lorazepam intensol concentrate (liquid anti-anxiety medication) give 0.25 mL by mouth every four hours as needed for anxiety and restlessness for 14 days. 5/19/25 1:54 PM - A physician's order was written for regular diet, mechanical soft texture, nectar consistency, for dysphagia. Provide extra pudding, ice cream, and sectional plate. 5/21/25 2:32 PM - A nutrition progress note documented R23 "had a diet changed to mechanical soft texture, nectar consistency, for dysphagia. Provide extra pudding and ice cream per physician's order, will continue to monitor." 5/2025 - A hospice visit discription log (provided from Hospice provider binder) documented that R23 had received visits on the following dates: -5/6/25; -5/13/25;	{F 684}	2-weeks. Despite the education of the process to all Hospice companies contracted with residents in the Facility, Hospice did not sign the paper "Progress Note Form" indicating their agreement with the change. And, when the forms were audited for placement and signature of the facility's attending and Unit Manager/Supervisor, there was not an audit to ensure the Hospice facility representative signed the form. The DON, or designee, will now also audit the paper "Progress Note Form" for the Hospice employee's signature to ensure Hospice complies with our policy. The Staff Development nurse, or designee, will re-educate all licensed nursing staff, the providers, and Hospice agencies on the new Hospice process. 4.a. DON (or designee) will conduct audits of medication carts daily x 3 to ensure all orally inhaled medications are located in the correct pocket behind the correct room divider, 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. 4.b. DON (or designee) will conduct audits of new orders for Hospice Residents to	

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{F 684}	Continued From page 4 -5/15/25; -5/20/25; -5/27/25. 6/2/25 12:00 PM - During an interview, E3 (RN) and E4 (RN UM) confirmed that the expectation is the Hospice nurse was supposed to check and sign off the forms in the book to acknowledge any update or new orders for the residents. 6/2/25 12:15 PM - During an interview, E2 (DON) confirmed that the hospice provider signature on the Hospice Provider Form was reviewed and that the provider accepted any new recommendations the facility had implemented in the resident's plan of care. E2 stated that the expected process was for the staff nurse on duty to review the Hospice Provider Form with the hospice nurse and ensure it was signed. E2 also confirmed that the referenced Hospice Provider Forms were not signed. The facility lacked evidence that the Hospice providers had reviewed and accepted the aforementioned recommendations to R23's plan of care. 6/2/25 2:30 PM - Findings were reviewed with E1 (NHA) during the exit conference.	{F 684}	ensure the Hospice was notified and all signatures on the "Progress Note Form" when Hospice is next in the building, 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.	
{F 688} SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range	{F 688}		6/19/25

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{F 688}	Continued From page 5 of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that for one (R4) out of nineteen residents in the investigative sample, the facility failed to provide R4 with a left-hand splint as ordered by the physician. Findings include: Review of R4's clinical record revealed: 1/31/18 - R4 was admitted to the facility. 2/6/18 - A care plan was initiated for ADL self-care performance deficit related to contractures with the following, but not limited to, interventions: apply splint to left hand in AM and remove before bedtime: check skin after removal and notify nurse if any changes, contractures: R23 had contractures of left hand and provide skin care to prevent breakdown, and PT OT evaluations as ordered. 4/16/25 10:47 AM - A physician's order documented that R23 was to have splint applied to left hand in AM and remove before bedtime every day.	{F 688}	1. Unable to correct in the past 2. All residents with orthotics have potential to be affected. DON, or designee, will audit residents with orthotics to ensure donning and doffing as ordered is followed by June 13, 2025. 3. RCA: It is the licensed professional's responsibility to Donn and Doff the assistive device, and to notify provider if resident refuses application of assistive device, with documentation placed in the electronic medical record. Previously, all nursing staff had the ability to apply splints. The order for the donning and doffing of the splint required the order to appear on the TAR, not the MAR. The professional nurses did not see the order on their electronic medication administration record (MAR) during their morning medication pass, and had not yet looked at the electronic treatment administration record (TAR) to know the	

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{F 688}	Continued From page 6 5/28/25 - A quaterly MDS documented that R23 had bilateral upper-extremity impairments and was dependent for all ADL's. 5/29/25 10:00 AM - An observation of R23 not wearing a left hand splint. 5/29/25 12:40 PM - An observation of R23 not wearing a left hand splint. 5/29/25 1:47 PM - An observation of R23 not wearing a left hand splint. 5/29/25 1:50 PM - During an interview, E11 confirmed that R23 did not have a splint on the left hand and confirmed that any staff could apply a splint when it is ordered. 5/30/25 10:05 AM - An observation of R23 not wearing a left hand splint. 5/30/25 10:55 AM - During an interview, E9 (CNA) confirmed that R23 did not have a splint on the left hand and stated that usually the splint would be applied after morning bath. E9 stated she was about to give R23 his bath and will apply the splint to the left hand when the bath is completed. 5/30/25 12:10 PM - During an interview, E10 (LPN) confirmed that a nurse was responsible to apply a splint and confirmed that R23 should have had his splint applied at 8:00 AM. E10 confirmed that she did not apply the splint to R23's left hand at 8:00 AM. 6/2/25 2:30 PM - Findings were reviewed with E1 (NHA) during the exit conference.	{F 688}	splint needed to be applied. Also, there was confusion on the part of the Certified Nursing Assistants (CNAs), as the same task was included in several portions of the Plan of Care, making it appear multiple times on the CNAs point of care dashboard. All orders for splints will now be written for the Licensed Nurse to Donn on the daytime shift and will be assigned to appear on the MAR, not the TAR. The EMR requires an actual time to be entered in the order. The time will be ordered for 9am, unless otherwise specified by the provider's order, so that the licensed nurse will see the order to Donn the splint/orthotic during their first morning medication pass. The Staff Development Nurse (or designee) will educate all nursing staff on the new process of following orthotic orders, documentation of donning/doffing, and who may apply an orthotic. 4. DON (or designee) will conduct audits of residents with orthotic orders daily x 3 to ensure the orders are being followed with proper donning and doffing by licensed nursing personnel only, 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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{F 700} SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that for three (R1, R5, and R13) out of nineteen in the investigative sample, the facility failed to obtain consents from the resident/POA/resident representative before utilizing bed rails/ enablers. Findings include: 1. Review of R1's clinical record revealed: 8/4/23 - R1 was admitted to the facility. 3/5/25 - A quaterly MDS documented that R1 was cognitively intact and R1 requires	{F 700}	1. R5, R47, R27, R23 were evaluated for the need for enablers by May 10th and, consents, and orders as required by May 28th, 2025. Although the therapy assessment did not determine enablers were needed for R5, the Resident Representative stated she wanted the enablers on the bed and signed the consent. 2. All residents with enablers have potential to be affected. DON or designee audited all residents with enablers for	6/24/25

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{F 700}	Continued From page 8 maximum/substantial assist with ADL's and bed mobility. 3/13/25 - A mobility assessment documented that R1 will "continue to need bed rails to bilateral sides to assist with bed moblity during care." 5/29/25 10:15 AM - An observation of R1 in bed with bilateral bed rails noted to head of the bed. 5/29/25 10:40 AM - A review of R1's EMR lacked evidence of a signed consent form for bed rail use. 5/29/25 11:15 AM - During an interview, E2 (DON) stated that the consents were completed and provided to the facility on 5/28/25. E2 stated that the facility was actively working to complete the PT assessments for indication of bed rail use for all residents and confirmed that the consents had not been completed for the facility due to receiving consents being available on the aforementioned date. E2 confirmed that R1 did not have a consent completed at this time for bed rail use. 2. Review of R5's clinical record revealed: 1/31/18 - R5 was admitted to the facility. 2/27/25 - A quaterly assessment documented that R5 was severaly cognitively impaired and was dependent for all ADL's. 4/17/25 - A mobility assessment for R5 documented that "Patient [R5] at this time does not appear to be able to benefit from the use of bed enablers at this time."	{F 700}	need as of May 10, 2025. DON or designee audited all residents with enablers for orders and signed consents as of June 11, 2025. Those without orders or consents had enablers removed from their beds. 3. RCA: knowledge deficit related to knowing that Enablers are considered Bedrails in LTC. A new process was instituted for the Therapy department to screen for enabler use for mobility for all new residents upon admission and again when requested for resident changes. The facility created a policy for enablers called: "Proper Use of Enablers". The facility created a consent for use of enablers. The therapy department will screen residents upon admission and when requested for changes for enabler use for mobility. Although all therapy screenings were completed as of May 10th, 2025, the policy and consent form was not approved until May 23, 2025. Therefore, consents were not on all resident charts at the time of resurvey. All orders and consents were completed by June 9th, 2025, for all residents in the facility as of that date. Those without an order or consent had their enablers removed by maintenance. Enabler consent forms will now be included in the Nursing Admission packet for the resident or resident representative to sign upon admission to the facility. Once enabler consent form is signed or declined, it will be scanned into the	

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(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 700}	Continued From page 9 5/29/25 10:00 AM - An observation of R5 in bed with bilateral bed rails noted to head of bed. 5/29/25 10:42 AM - A review of R5's EMR lacked evidence of a signed consent form for bed rail use. 5/29/25 11:15 AM - During an interview, E2 (DON) stated that the consents were completed and provided to the facility on 5/28/25. E2 stated that the facility was actively working to complete the PT assessments for indication of bed rail use for all residents and confirmed that the consents had not been completed for the facility due to receiving consents being available on the aforementioned date. E2 confirmed that R5 did not have a consent completed at this time for bed rail use. 3. Review of R13's clinical record revealed: 5/17/25 - An MDS assessment documented that R13 was moderately impaired. 5/23/25 - A mobility assessment documented, "Patient continue to benefit from bilateral bed enablers during care." 5/28/25 1:40 PM - R13 was observed in bed with bilateral rails/enablers raised. Immediate review of R13's clinical record lacked evidence of a signed consent for the rails/enablers. 5/30/25 9:15 AM - During an interview E2(DON) confirmed the facility did not have a signed consent for rails for R13. 6/2/25 2:30 PM - Findings were reviewed with E1 (NHA) during the exit conference.	{F 700}	resident's electronic medical record. Audits will be completed on all new admissions, by the DON, or designee, to ensure the therapy screening, enabler order, and consent form is present on the resident's chart of all new residents with enablers on their beds, as noted below to ensure compliance. If the therapy screener determines the resident will not benefit, and the Resident or their Resident Representative does not sign a consent for the enabler despite the findings, no order will be placed, and the enablers will be removed by the Maintenance department on the next business day. The Staff Developer (or designee) educated licensed nursing staff on the new policy and need to obtain consent of enablers if recommended by therapy department during the May skills fair that ended May 25, 2025. The Staff Development RN (or designee) will educate the UM/Supervisors on their role to obtain consent for all new residents, explaining to the resident/resident representative whether therapy deemed the resident to be appropriate for enablers. And, if the resident or their representative wants the enablers despite therapy's recommendation, the enablers will remain on the bed, otherwise they will be removed by Maintenance Department on the next business day. 4. DON (or designee) will conduct audits of new residents with enablers as of June	

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{F 700}	Continued From page 10	{F 700}	10, 2025 daily x 3 to ensure they have been screened and deemed appropriate for enablers by therapy department, have a signed consent, and have an order for the enablers, 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.	
{F 755} SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	{F 755}		6/24/25

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{F 755}	Continued From page 11 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for three (R14, R17 and R23) out of three residents reviewed for pharmacy services, the facility failed to provide pharmaceutical services to meet the needs of each resident. Findings include: 1. Review of R17's clinical record revealed: 11/23/20 - R17 was admitted to the facility. 12/28/23 - A physician's order was written for R17 to receive sevelamer carbonate oral packet 2.4 grams give one packet via Peg-Tube (medical device used to provide nutrition) with meals for dialysis, must be given with meals. 5/19/25 6:35 PM - A progress note for R17 documented that sevelamer carbonate is not available. 5/20/25 11:37 AM - A progress note for R17 documented that sevelamer carbonate is unavailable. Medication supplied by a dialysis facility. The RN supervisor was made aware and contacted the dialysis facility. 5/21/25 8:57 AM - A progress note for R17 documented that sevelamer carbonate is not	{F 755}	1. Unable to correct in the past 2. All residents have the potential to be affected. Nursing Supervisor runs a missing medication report every shift to monitor medication availability and contacts the pharmacy regarding delivery status and updates. Physician and DON notified of outcomes daily. 3. RCA: The pharmacy continues to defer delivery of medications, telling Kutz staff the medications are not available. On 4/8/25, the Senior Vice President (VP) of the pharmacy met virtually with LNHA and DON. The pharmacy VP acknowledged the Pharmacy provider was experiencing financial hardships, so they were unable to purchase all medications, or obtain the medications from the "emergency" back-up local pharmacy as required in our Pharmacy contract, but were in the middle of an acquisition that would solve this issue. The VP assured the DON & LNHA that the acquisition would be happening in a few weeks and would solve the issues the facility was experiencing. The VP promised he would personally ensure the facility receive the residents' medications	

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{F 755}	Continued From page 12 available, supervisor made aware. 5/29/25 - Review of R17's medication administration record (MAR) documented the following missed doses of Sevelamer Carbonate: 5/19/25, 5/20/25, 5/21/25. 5/30/25 11:32 AM - During an interview, E3 (UM) confirmed sevelamer carbonate was not administered to R17 on 5/19/25, 5/20/25 and 5/21/25. 6/2/25 1:45 PM - During an interview, E2 (DON) confirmed the findings and reported the medication sevelemer was sent from a dialysis facility on 5/19/25 but there was a lack of evidence as to when the medication arrived to this facility. 2. Review of R14's clinical record revealed: 10/4/23 - A physicians order was written for R14 to receive cetirizine HCl Oral Tablet 10 mg for allergies daily. 10/4/23 - A physicians order was written for R14 to receive cyanocobalamin Oral Tablet 500 MCG (vitamin B12) daily for low blood count. 5/11/25 8:14 AM A note in R14's clinical record documented that the cyanocobalamin was "unavailable." 5/15/25 8:57 AM - A note in R14's clinical record documented that the cetirizine was "unavailable. Pharmacy made aware." May 2025 - Review of R14's MAR documented the following missed doses of medication:	{F 755}	timely, and there would be no issues moving forward. Despite these assurances, the acquisition never occurred, and it appears a new acquisition is in the works as of June 12, 2025. Kutz continues to experience delays in obtaining medications for their residents. Due to continuing issues with obtaining resident medications, the NHA and DON met with a new pharmacy on 4/22/2025 and again on 6/16/2025 and 6/18/2025, to discuss transitioning to the new pharmacy. Integration with the Electronic medical record takes approximately 6-8 weeks, which prevents this transition from occurring any earlier. A contract was signed with the new pharmacy on 6/19/25 and cancellation notice was sent to the current pharmacy on 6/19/2025, to end services between 8/1/2025 and 8/30/2025. The new pharmacy's Nursing Educators will educate the facility's nursing staff on their new procedures and processes, prior to their implementation date. New pharmacy has guaranteed resident medications will be received at the facility within 24 hours of ordering. Pharmacy will contact Provider directly if medications are not approved by their insurance, to get approval or new orders. Pharmacy guaranteed they will utilize Emergency pharmacy in Wilmington area for medications not available from their pharmacy within 24 hours Starting on 6/20/2025 the pharmacy will	

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{F 755}	Continued From page 13 5/11/25 - cyanocobalamin. 5/15/25 - cetirizine. 5/30/25 12:19 PM - During an interview E1 (NHA) confirmed the findings and reported the facility will be switching pharmacies in the near future. 6/2/25 2:30 PM - Findings were reviewed with E1 (NHA) during the exit conference. 3. Review of R23's clinical record revealed: 9/19/24 - R23 was admitted to the facility. 4/14/25 - R23 was admitted to the Hospice. 5/14/25 7:00 PM - A physician's order was written for lorazepam intensol concentrate (liquid anti-anxiety medication) give 0.25 mL by mouth every four hours as needed for anxiety and restlessness. 5/14/25 7:02 PM - A progress note documented that R23 was having anxiety and restlessness and the provider ordered the aforementioned medication. 5/15/25 7:37 PM - A progress note documented that R23 had not received lorazepam due to waiting on delivery from pharmacy. 5/16/25 10:45 AM - A physician's order was written for lorazepam intensol concentrate (liquid anti-anxiety medication) give 0.25 mL by mouth every four hours as needed for anxiety and restlessness for 14 days.	{F 755}	email daily the DON and LNHA a "Profile Predictive Report" for the Passport medication dispensing machine, which delineates the current number of doses of the medication in the machine, and the number of doses required until the next fill. The daily call initiated on May 12, 2025 with the current pharmacy Vice President, Lead Pharmacist, and the facility's LNHA and DON will continue to address all medications on the "Pharmacy Concerns" form, any discrepancies on the Profile Predictive Report, and discuss alternative delivery options on a daily basis (excluding weekends and holidays) to mitigate missing medications in a timelier manner. If the missing/unavailable medication is not received timely, and is not on a national backorder, the DON (or designee) will contact provider for an order to obtain the medication from a local pharmacy. Until the conversion to the new pharmacy occurs, nurses will notify the UM/Supervisor of all unavailable or missing medications. The UM/Supervisor (or designee) will contact the pharmacy for an update on delivery status and communicate the answer with the physician for further instructions/orders. The UM/Supervisor (or designee) will also run a missing medications report from the EMR every shift to identify lack of availability of any resident medications to ensure none are missed. UM/Supervisor will document all unavailable/missing medications on the	

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{F 755}	Continued From page 14 6/2/25 11:45 AM - A pharmacy requistion form documented that lorazepam intensol concentrate was shipped on 5/16/25. 6/2/25 1:30 PM - During an interview, E3 (RN) confirmed that R23 did not receive lorazepam during the aforementioned timeframe and confirmed that the medication was not available. 6/2/25 1:45 PM - During an interview, E2 (DON) confirmed that the lorazepam for R23 was not available and consequently not administered from 5/14/25 to 5/16/25 and confirmed that the pharmacy did not ship the medication until 5/16/25. E2 also confirmed that the medication was delivered after 3 PM on 5/16/25. 6/2/25 2:30 PM - Findings were reviewed with E1 (NHA) during the exit conference.	{F 755}	designated "Pharmacy Concerns" form, to include results of calls to pharmacy with when medication will be delivered, and who they spoke with. The UM/Supervisor (or designee) will then write a "Communication to Physician" Progress Note in the EMR with the results of call to provider addressing missing/unavailable medications and any new orders received. Staff Development Nurse (or designee) will educate Staff Development Nurse (or designee) will educate all licensed nurses on the process for unavailable or missing medications, which includes notifying the UM/Supervisor. UM/Supervisor will document all unavailable/missing medications on the designated "Pharmacy Concerns" form, to include results of call to pharmacy with when medication will be delivered, and who they spoke with. The UM/Supervisor (or designee) will then write a "Communication to Physician" Progress Note in the EMR addressing missing/unavailable medications and any new orders received. 4. DON (or designee) will conduct audits of missing medications daily x 3 to ensure a provider order was obtained, 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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{F 760}	Continued From page 15	{F 760}		
{F 760} SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R9) out of three residents reviewed for medications, the facility failed to ensure the residents were free from significant medication errors when R9 was administered the wrong pain medication, oxycodone instead of OxyContin. Findings include: The Facility's Medication Administration Policy last revised 4/2025 indicated "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physicians and in accordance with professional standards of practice, in a manner to prevent contamination or infection... 10. Ensure that the six rights of medication administration are followed: a. right resident, b. right drug, c. right dosage, d. right route, e. right time, f. right documentation. 11. Review MAR (Medication Administration Record) to identify medication to be administered...". Review of R9's clinical record revealed: 4/28/25 - R9 was admitted the facility with multiple diagnoses including a broken leg. 4/28/25 - A physicians order was written for R9 to receive oxycodone 10 mg [short acting pain medicine] every four hours as needed for pain.	{F 760}	1. Unable to correct in the past. 2. Unable to correct in the past. 3. RCA: E7 had only been off orientation about 1 month when the incident occurred. E7 completed a Medication Administration Competency with the Staff Development RN on 5/21/2025 which included checking the medication label against the medication order on the MAR. During the annual skills fair E7 attended on 5/21/25, proper medication administration (including the right medication at the right time) was discussed. E7 stated she was distracted because she was worried about another one of her residents who was not doing well. There was nothing in the narcotic drawer separating the medications by residents/resident rooms. The ADON gave on the spot education to E7 on 5/27/2025, with additional education to be provided by the Staff Development RN or designee upon return from leave. Additional education was provided to E7 on 6/10/2025 related to the 5 rights of medication administration, and decreasing distractions during resident medication passes by the LNHA.	6/19/25

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{F 760}	Continued From page 16 5/14/25 - A physicians order was written for R9 to receive OxyContin 20 mg [long acting pain medicine] every twelve hours, at 9:00 AM and 9:00 PM for severe pain. 5/25/25 8:32 AM - A facility incident report documented that R9 was administered oxycodone 5 mg instead of Oxycontin 20 mg from another residents blister pack. An accompanying statement written by E7 documented, "Medication was removed from the wrong blister pack." 5/25/25 1:46 PM - A nurses note in R9's clinical record written by E7 (LPN) documented, "Resident was administered oxycodone 5 mg instead of OxyContin 20mg from another residents blister pack. Resident does have a PRN order for Oxycodone 10 mg. Notified on call MD & RR, Resident on alert charting/monitoring." 5/27/25 - E7 (LPN) received education on medication administration. 5/30/25 9:30 AM - During an interview E2 (DON) confirmed the findings. 6/2/25 2:30 PM - Findings were reviewed with E1 (NHA) during the exit conference.	{F 760}	Dividers with the residents' room number on them will be placed in the locked narcotics box in each medication cart so that the licensed nurse does not pull a card from the wrong resident/wrong room. Also, PRN stickers will be placed on all PRN bubble packs to delineate standing order medications from PRN medications. After receiving formal medication administration education, E7's medication administration will be monitored via a weekly audit x 4. 4. DON (or designee) will conduct audits of all medication administration carts daily x 3 to ensure narcotic boxes have room dividers properly placed to separate resident medications, 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.	