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 03/26/2025

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
F 760	Continued From page 90 EMR progress notes, "Sevelamer... not available from pharmacy...". 3/19/25 11PM - E33 (LPN) documented in R17's EMR progress notes, "Sevelamer... call out to pharmacy regarding med availability, med is being reordered this evening and will be out on next available run per [pharmacy staff] from pharmacy." 3/20/25 8:57 AM and 11:29 AM - E8 documented in R17's EMR progress notes, "Sevelamer... Medication on back order per pharmacy. MD made aware. NNO (no new orders) for a (sic) interchangeable medication." 3/20/25 6:15 PM - E32 documented in R17's EMR progress notes, "Sevelamer... not available from pharmacy. Pharmacy called...". 3/21/25 6:06 PM - E32 documented in R17's EMR progress notes, "Sevelamer... on back order from pharmacy...". 3/24/25 9:24 AM - E9 (RN) documented in R17's EMR progress notes, "Call nephrology in references to Sevelamer not covered through his [R17} insurance. Therefore, the medication is not delivered to us. Message left for the second time with Nephrology and awaiting return call." 3/24/25 3:24 PM - E9 documented in R17's EMR progress notes, "Spoke with nurse from Dialysis in reference to Sevelamer not been (sic) covered by his [R17's} insurance and prior auth needs to be send (sic) to pharmacy in order for prescription to be filled. [E11 (contracted MD)] made aware. "	F 760		

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 03/26/2025

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
F 760	Continued From page 91 The facility failed to notify the dialysis center that R17 was not receiving his ordered Sevelamer prior to 3/24/25. 3/24/25 6:43 PM - E31 documented in R17's EMR progress notes, Sevelamer... not available." 3/25/25 9:16 AM - E8 documented in R17's EMR progress notes, "Sevelamer... Spoke with pharmacy, medication is on order and will be sent out as soon as they receive medication." 3/25/25 11:15 AM - Review of R17's March 2025 MAR revealed that R17 missed thirty-two of the seventy-three scheduled dosages of Sevelamer for the month of March 2025. 4.Review of R41's clinical record revealed: Cross refer F755, example 1 10/21/23 - R41 was admitted to the facility with multiple diagnoses, including human immunodeficiency virus (HIV) disease and chronic obstructive pulmonary disease (COPD). R41's medication orders included the following: -Dovato Oral Tablet 50-300 mg, give one tablet daily for antiviral. -Formoterol Fumarate Inhalation Nebulization Solution 20mcg/2ml, inhale 2 ml orally two times a day for COPD. 3/25/25 - A review of the Medication Administration Record (MAR) revealed that Dovato and Formoterol medications were not administered on the following dates: Dovato	F 760		

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 03/26/2025

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
F 760	Continued From page 92 1/13/25, 1/14/25, 2/15/25, 2/16/25, 2/18/25, 2/19/25, 3/24/25, and 3/25/25. Formoterol 2/6/25 AM, 2/23/25 AM, 2/26/25 AM, 3/17/25 PM thru 3/22/25 AM. 3/25/25 10:15 AM - During an interview, E9 (RN) confirmed the missing doses of medication of Dovato and Formoterol. 3/26/25 11:45 AM - Finding was reviewed during the exit conference with E1 (CEO/LNHA), E2, E3 (SD/ICP) and nine department managers/representatives.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		5/10/25

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 03/26/2025

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
F 761	Continued From page 93 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one out of three medication carts observed, the facility failed to adhere to proper labeling and storage practices for insulin pens as per regulatory standards and best practices. Findings Include: 3/20/25 12:00 PM - Upon observation of insulin administration for R61, the surveyor observed that the insulin aspart pen was open and used, but there was no indication of an open date on the medication. The absence of an open date on the insulin pen created a risk of using expired medication, which could compromise resident safety and treatment efficacy. 3/20/25 12:01 PM - Interview with E8 (LPN) confirmed that no open date was labeled on the pen. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 (SD/ICP) and nine department managers/representatives.	F 761	1. A new insulin pen was ordered from the pharmacy, received and replaced on 3/20/25 by Staff Development nurse and properly labeled LPN E8. 2. All residents with multi-dose medication containers have potential to be affected. DON, or designee, will audit residents with multi-dose medication containers for proper labeling to include residents□ name & date of birth, and expiration date by May 5, 2025. 3. RCA: Professional nursing staff missed labeling one pen due to rushing. The facility will use Bright Red "Discard after" stickers, which will be applied to all multi dose containers (i.e.: Insulin Pens) to have date put on them when they are opened. New Pharmacy will send pen with patient label already affixed, to include name and Date of Birth. DON, or designee, will educate professional nurses on proper labeling of multi-dose containers for resident medications, and to the large bright red sticker that says, "Date expires" and to document the correct date on the label. 4. DON (or designee) will conduct audits	

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 03/26/2025

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
F 761	Continued From page 94	F 761	of multi-dose medication containers daily x 3 to ensure the stickers are in place with the correct names and dates, 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 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F 842		5/10/25

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 03/26/2025

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
F 842	Continued From page 95 (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic	F 842		

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 03/26/2025

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
F 842	Continued From page 96 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R27 and R42) out of eight residents reviewed for falls, the facility failed to ensure that each resident had a complete and accurate medical record. Findings include: 1. Review of R27's clinical record revealed: 4/12/21 - R27 was admitted to the facility with multiple diagnoses, including a history of falls, history of a fracture, osteoporosis and arthritis. 7/3/24 - A MDS assessment completed for R27 documented that she was frequently incontinent of bowel and bladder. 7/11/24 10:30 AM - R27 had a fall out or bed as she was being provided personal hygiene. 7/12/24 - A post fall risk assessment was completed for R27 which documented that she had 1-2 predisposing diseases that could contribute to a fall. R27 actually had three (3) predisposing disease (arthritis, osteoporosis and previous fractures) that would contribute to her increased fall risk. 8/9/24 - R27 experienced a fall while she was being showered. A post fall risk assessment was completed for R27 that documented the following: -R27 did not have any falls in the last three months. R27 had a fall on 7/11/24. -R27 was chairbound and continent.	F 842	1. The current fall risk evaluations for R27 and R42 will be assessed for accuracy and if needed a new Fall Risk Evaluation will be completed, and if needed the care plan will be adjusted by 5/5/2025. 2. All residents at risk of falls have potential to be affected. DON, or designee, will audit resident Fall Risk Evaluation for April for accuracy, and a new Fall Risk Evaluation will be completed, and care plan adjusted, if needed. 3. RCA: Professional nursing staff rush through the assessments and do not always note previous falls or medical diagnoses. Staff Development Nurse, or designee, will re-educate professional nursing staff on how to correctly complete the Fall Risk Evaluation by reviewing the Risk Management tab in the EMR for the number of falls in the past three months, and the Medical Diagnosis tab in the EMR for diagnoses that predispose residents for a fall, prior to completing the form. 4. DON (or designee) will conduct audits of Fall Risk Evaluation forms to ensure the number of falls in the past 3 months that predispose residents to falls and the number of medical diagnoses that predispose residents to falls are documented correctly, daily x 3, until	

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 03/26/2025

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
F 842	Continued From page 97 - R27 had 1-2 predisposing diseases that could contribute to a fall. R27 actually had three (3) predisposing diseases (arthritis, osteoporosis and previous fractures) that would contribute to her increased fall risk. 3/24/25 - During an interview, E9 (RN) confirmed that R27 had the following: -For the 7/12/24 and the 8/9/24 fall risk assessments, that R27 had three (3) diseases that could predispose her to a fall, instead of the two (2) predisposing diseases that the fall risk assessments listed. - The 8/9/24 fall risk assessment should have captured that R27 had a fall that had occurred within the last three months, and that R27 was frequently incontinent. R27's 7/12/24 and 8/9/24 fall risk assessments did not correctly capture all of the risk factors that placed R27 at an increased risk for falls. 2. Review of R42's clinical record revealed: 7/27/24 4:07 PM - A nurse's note documented that R42 was found on her bedroom floor. 8/14/24 3:27 AM - A nurse's note documented that R42 was found at 2:30 AM on her bedroom floor mat and was sent to the emergency room for evaluation. 9/14/24 - The Fall Risk Evaluation documented that R42 had no falls in the past three (3) months. The facility failed to accurately complete R42's Fall Risk Assessment with respect to two	F 842	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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 03/26/2025

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
F 842	Continued From page 98 previous falls. 3/21/25 9:09 AM - During an interview, finding was reviewed E2 (DON). No further information was provided to the Surveyor. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2, E3 (SD/ICP) and nine department managers/representatives.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators.	F 867		5/10/25

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 03/26/2025

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
F 867	Continued From page 99 §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its	F 867		

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 03/26/2025

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
F 867	Continued From page 100 performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	F 867		

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 03/26/2025

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
F 867	Continued From page 101 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview, record review and identified deficiencies during the survey, it was determined that the facility's QAPI program failed to effectively address ongoing issues that impact quality of care with respect to staff to resident abuse, repeated medication errors by nursing staff and the continued lack of availability of medications from the pharmacy for multiple residents. Findings include: 3/25/25 1:08 PM - During a combined interview with E1 (CEO/LNHA) and E2 (DON), E1 stated that the QAPI Committee discusses all medication errors in their meetings. E1 mentioned that the 10/3/24 medication error incident involving four residents was reviewed and staff nurses were educated in November 2024. The Surveyor reviewed that there were additional medication errors on 1/3/25 and 2/11/25. E2 stated that the facility provided education in November 2024, December 2024 and again in February 2025. Also Supervisors started doing medication pass audits after the 2/11/25 incident. The Surveyor was informed that the facility has not had a consistent Staff Development nurse and they have not been able to conduct a skills fair for staff. While the medication errors by nursing are routinely discussed during the QAPI meetings and staff education was provided, the facility's	F 867	1. Not Applicable. 2. Not Applicable. 3. RCA: The facility maintains a robust QAPI infrastructure with routine meetings that review PowerPoint graphs drawn from a spreadsheet of trending of dozens of clinical and operational data, a weekly High-Risk Committee that channels urgent issues to the agenda, and a two-tier model that directs most concerns to rapid Plan-Do-Study-Act (PDSA) cycles while reserving a single, formal Performance-Improvement Project for the highest-risk theme each year. However, the process can be improved by adopting uniform documentation tools so every action is clearly recorded and readily visible to reviewers. The facility will, with the next QAPI meeting, use the one-page Priority-Scoring Matrix (risk, volume, problem-prone, trend) to rate the current issues of abuse, medication errors and lack of on time medication provision, along with each new issue□scores of 9 or higher will trigger a time-bound PDSA cycle, while scores of 8 or lower will remain on the watch list□and every	

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 03/26/2025

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
F 867	Continued From page 102 QAPI Committee documentation lacked evidence of measurable goals, what systemic changes were implemented and monitoring the performance to ensure the changes were successful and sustained. Medication audits provided and reviewed by the Surveyor were done on 2/5/25 and 2/11/25. No additional information was provided. An additional concern identified during the survey was about the lack of availability of medications for some residents, E1 stated that this was discussed in the last QAPI meeting in March 2025 (during the survey) where the pharmacy representative was present. Surveyor asked about how do you get information about residents' medications not being available? E2 stated that they [Management] are notified by nursing staff when they bring it to their attention. E1 and E2 confirmed that there have been issues with the current pharmacy since October 2024. Surveyor was told that since October 2024, it would improve at times, but for the past month there have been issues with obtaining residents' medications. With respect to the two incidents of staff to resident abuse on 12/22/24 and 1/15/25 and both identified in the current survey as deficiencies, E1 confirmed that there was no current PIP (performance improvement plan) for abuse. E1 stated that the QAPI Committee discusses abuse at each meeting. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1, E2, E3 (SD/ICP) and nine department managers/representatives.	F 867	resulting cycle will be documented on a standardized one-page PDSA worksheet that records the problem statement, measures/goals, interventions, responsible person, and due date. 4. NHA (or designee) will conduct audits of QAPI meeting minutes monthly x 3 to ensure use of the Priority-Scoring Matrix and PDSA worksheet, 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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 03/26/2025

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
F 880	Continued From page 103	F 880		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		5/10/25

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 03/26/2025

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
F 880	Continued From page 104 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that one (R78) out of ten residents reviewed for Infection Control, the facility failed to order and maintain Enhanced Barrier Precautions (EBP) for R78 when he had an indwelling catheter from 3/28/24 to 12/13/24. Findings include: Facility's Enhanced Barrier Precaution policy - "...	F 880	1. Unable to correct in the past. 2. An audit of all residents in the facility was completed by Staff Developer 04/30/2025 to ensure all residents needing EBP have them ordered. All residents with multidrug-resistant organisms (MDROs), indwelling devices,	

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 03/26/2025

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
F 880	Continued From page 105 refer to infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and gloves use during high contact resident care activities... 2. Initiation of Enhanced Barrier Precautions:... b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds.... And /or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO... 4. High-contact resident care activities include:... g. Device care or use: central lines urinary catheters...". 12/6/23 - R78 was admitted to the facility with diagnoses including, but were not limited to, emphysema, neurogenic bladder and obstructive uropathy. 12/6/23 - E4 (contracted MD) ordered in R78's EMR, "Foley catheter care every shift. Flush foley catheter with 60 ml (milliliter) of sterile water Q (every) shift for Infection prevention." 3/5/24 - E4 reordered in R78's EMR , "Flush foley catheter with 60 ml of sterile water Q shift for Infection prevention." This order meant that during each shift, the nursing staff (nurses and CNAs) would have high-contact with R78 as they worked with his urinary catheter and flushed it with 60 mls of sterile water. 4/1/24 - The Centers for Medicare and Medicaid Services (CMS)'s "Enhanced Barrier Precautions in Nursing Homes" recommendations become	F 880	and chronic wounds require careful attention as they have the potential to be affected. The Staff Development nurse conducted an audit of all residents to ensure that the necessary infection prevention (EBP) orders were implemented accordingly by 4/30/2025. 3. RCA: EBP was not implemented until November while the resident was out at the hospital. Implementation was missed upon return from hospital. The facility implemented a weekly Antibiotic Stewardship meeting in April 2025, which includes the SD/IPCO, DON or designee, and Medical Director or designee. All residents will be reviewed for EBP at clinical rounds, and at the weekly Antibiotic Stewardship meeting to ensure compliance. 4. SD/IPCO (or designee) will conduct audits of residents with multidrug-resistant organisms (MDROs), indwelling devices, and chronic wounds daily x 3 to ensure ty have EBP are assigned 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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 03/26/2025

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
F 880	Continued From page 106 effective as part of the F880 Infection Prevention and Control regulation. 12/19/24 - E4 reordered in R78's EMR, "Foley catheter care every shift." 3/11/25 2:20 PM - While reviewing R78's order recap for his entire stay at [facility], the Surveyor noted there was no order for EBP. The facility was not able to provide evidence that R78 was placed on EBP at any point during his admission. 3/13/25 12:34 PM - During an interview, E15 (LPN) stated, "[R78] did have a foley catheter while he resided here. I don't recall him being on any type of precautions." 3/21/25 4:16 PM - During an interview, E3 (SD/ICP) stated, "We did not start EBP until November 2024 in this facility." 12/31/24 - R78 died on hospice care. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 and nine department managers/representatives.	F 880		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 881		5/10/25

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 03/26/2025

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
F 881	Continued From page 107 §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R45) out of ten residents reviewed for antibiotic use, the facility failed to ensure that an antibiotic stewardship program was implemented that consistently monitored prescription antibiotic usage. Findings include: Facility's "Definitions Policy per McGreer's - It is the policy of this facility to adhere to the definition of infection listed below when conducting monthly surveillance of infections... Colonization - term used to describe the presence of bacteria, viruses, or other microscopic organisms that are not causing adverse clinical s/s [signs or symptoms], Fever - single oral T [temperature] 100 degrees F [Fahrenheit] or repeated oral T > [greater] 99 degrees F, or a single T > 2 degrees F over baseline from any site,... Leukocytosis - neutrophilia [> 14,000 leukocytes (white blood cells)/ mm3] or left shift [6 % bands or >/= 1,500 bands/mm3]...". Facility's "Antibiotic Stewardship Program - The purpose of the program is to reduce inappropriate use of antibiotics, improve resident outcomes and lessen adverse events... Policy explanation and compliance guidelines:... 4. The physician will refer to the appropriate algorithm for prescribing antibiotics and will document his/her findings in the resident's medical record...". Date reviewed/revised 12/2024 Review of R45's clinical record:	F 881	1. Unable to correct in the past. 2. All residents with antibiotics ordered have potential to be affected. IPCO will audit residents with infections to ensure they meet McGreer's criteria for antibiotics By April 30, 2025. If the resident does not meet criteria, the physician will be notified and a D/C order for the antibiotics will be requested. 3. RCA: Hospital communication is not in place to obtain microbiology results of cultures after resident leaves hospital setting. Kutz staff do not have the ability to retrieve laboratory results once the resident is discharged from the acute Hospital. New process to have Nursing Supervisor call the On-call physician for results not resulted before transfer from Acute Care hospital to Kutz Rehabilitation and Nursing. If results do not meet McGreer's criteria for continued antibiotic use, the On-call physician will be asked to discontinue the antibiotic order. Additionally, all lab results will be discussed at the weekly Antibiotic Stewardship meeting. IP Nurse will educate Nursing Supervisors/Unit Managers on new process for obtaining lab results after resident returns to facility.	

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 03/26/2025

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
F 881	Continued From page 108 6/19/24 - R45 was admitted to the facility with diagnoses including, but were not limited to, dementia and irritable bowel syndrome with diarrhea. 6/19/24 - R45's medication allergies were listed in the EMR as oxycodone, remeron, penicillin, and erythromycin. 1. UTI (urinary tract infection) September 2024 9/24/24 5:26 AM - E51 (LPN) documented in R45's EMR progress notes, "Resident has asked to use the bathroom and has urinated 5+ times this shift." This was documentation of increased frequency of urination. 9/24/24 12:18 PM - E7 (LPN) documented in R45's EMR progress notes, "... resident was c/o (complaint of) painful urination...". This was documentation of painful urination. 9/26/24 3:06 PM - R45's voided urine sample culture was reported to the facility with final report: colony count 50,000 gram negative rods, Organism identification: E.coli. This culture report failed to meet McGreer's criteria for UTI without an indwelling catheter as the microbiologic colony count was less than 100,000 cfu/ml. 9/27/24 - E11 (contracted MD) ordered in R45's EMR, "Bactrim DS tablet 800- 160 mg (sulfamethoxazole- trimethoprim)- give 1 tablet by mouth two times a day for cystitis (inflammation	F 881	4. IP (or designee) will conduct audits of residents with antibiotics ordered daily x 3 to ensure they meet McGreer□s criteria, until 100% compliance is achieved, and then weekly x 3 to ensure they meet criteria, 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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 03/26/2025

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
F 881	Continued From page 109 of the bladder) for 7 days." Review of R45's EMR vital signs revealed no fevers during the entire month of September 2024. R45's record review demonstrated that there was insufficient data to meet McGreer's criteria for infection surveillance that would necessitate an antibiotic. 2. UTI October 2024 10/10/24 - E4 (contracted MD) ordered in R45's EMR," Keflex oral capsule 500 mg (Cephalexin)- give 1 tab by mouth two times a day for UTI for 3 days." Review of R45's EMR lab results revealed that on 10/10/24 R45 had a urinalysis done, but a urine culture was not performed. The urinalysis revealed the specimen was negative for ketones and nitrites and bacteria was absent. There was a large number or urine leukesterase. Review of R45's EMR progress notes prior to and on 10/10/24 revealed no documentation of any pain on urination, fever, increased frequency, incontinence or urgency or gross hematuria. Review of R45's vital signs revealed no fevers for the entire month of October 2024. R45's record lacked sufficient data to meet McGreer's criteria for infection surveillance that would necessitate the use of an antibiotic. 3. UTI January 1, 2025	F 881		

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 03/26/2025

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
F 881	Continued From page 110 12/20/24 1:17 AM - E51 (LPN) documented in R45's EMR progress notes, "Resident stated that her body hurts all over." 1/1/25 -E11 (contracted MD) ordered in R45's EMR, "Bactrim DS oral tablet 800-160 mg (sulfamethoxazole-trimethoprim)- give 1 tablet by mouth two times a day for frequency, burning X 3 days. Start after urine collected." 1/2/25 12:00 AM - E30 (RN supervisor) documented in R45's EMR progress notes, "Primary nurse reported resident is having urine frequency and burning on urination. Afebrile... Bactrim DS one tab BID X 3 days to start after urine is collected." 1/3/25 8:12 PM - E11 discontinued Bactrim DS due to "rash to face and neck." 1/4/25 12:56 PM - R45's voided urine sample culture was reported to the facility with final report: colony count 50,000 gram negative rods, Organism identification: E.coli. 1/7/25 - Ciprofloxacin was added to R45's medication allergy profile. This culture report failed to meet McGreer's criteria for UTI without an indwelling catheter as the microbiologic colony count is less than 100,000 cfu/ml. R45's EMR vital signs lacked evidence of any fevers during the entire month of January 2025. 4. UTI January 15, 2025 1/15/25 - E11 ordered in R45's EMR, "Cefuroxime	F 881		

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 03/26/2025

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
F 881	Continued From page 111 Axetil oral tablet 250 mg- give 1 tablet by mouth two times a day for UTI for 5 days." This antibiotic was started as the result of R45's hospital ER visit on 1/15/25 after a fall. 1/15/25 1:44 AM - C5 (hospital emergency room MD) documented in R45's ED Physician Record, "ED (emergency department) progress... UA notable for 3+ LE (leukesterase), 11-20 WBCs (white blood cells), rare bacteria, consistent with UTI... Patient's recently completed course of Keflex for UTI 2 days ago, also was briefly on Bactrim, however reportedly this caused her to have a rash and so was stopped. Given persistent evidence for UTI on repeat UA here in the department, will give prescription for a 5day course of cefuroxime... CBC without leukocytosis... Stable for discharge...". 1/16/25 8:08 AM - Hospital lab final urine culture report documented "10,000 - 100,000 cfu/ml mixed gram positive and gram-negative growth. Mixed flora may represent colonization or contamination. Repeat collection if clinically indicated." The facility failed to follow up with the hospital lab to get the final culture report. R45's EMR vital signs revealed lacked evidence of fevers during the entire month of January 2025. 5. CAP (community acquired pneumonia) January 2025 1/22/25 - E51 (LPN) documented in R45's EMR progress notes, "Resident noted with a	F 881		

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 03/26/2025

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
F 881	Continued From page 112 non-productive cough at this time...". 1/23/25 12:52 PM - R45's CXR report revealed, "Lungs: bibasilar airspace opacities." 1/24/25 - E11 ordered in R45's EMR, "Doxycycline Hyclate oral capsule 100 mg- give 1 capsule by mouth two times a day for CAP for 5 days." R45's EMR vital signs lacked evidence of fevers, and respiratory rate ranged from 16 to 19 breaths per minute during the entire month of January 2025. R45's EMR lab results lacked evidence that a CBC lab work was drawn during the month of January 2025 so there was no documentation of leukocytosis. R45's record review demonstrated that there was insufficient data to meet McGreer's criteria for infection surveillance that would necessitate an antibiotic. The facility failed to ensure the facility's antibiotic stewardship program prevented the inappropriate use of antibiotics. On five separate occasions from September 2024 to January 2025, R45 was inappropriately prescribed antibiotics when her presenting symptoms did not meet McGreer's criteria. R45 has documented drug allergies to three classes of antibiotics: macrolide antibiotics (erythromycin), penicillin antibiotics and fluroquinolones antibiotics (cipro). The facility's failure to appropriately utilize antibiotics with R45, who already has a limited catalog of antibiotics	F 881		

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 03/26/2025

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
F 881	Continued From page 113 available for her usage, has the potential to create resistance to the antibiotics available to her. It should be noted that only two of R45's five infections were listed on the monthly antibiotic surveillance line listings that were reviewed for the months of September 2024 to February 2025. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 (SD/ICP) and nine department managers/representatives	F 881		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for one (R17) out of thirty-five (35) sampled residents reviewed, the facility failed to ensure that R17 had functioning call bell systems to request staff assistance. Findings include: Review of R17's clinical record revealed: 11/13/23 - R17 was admitted to the facility with diagnosis including, but was not limited to, end	F 919	1. Unable to correct in the past. 2. All residents with a MDS score of 00 for ADL's have the potential to be affected. The DON, or designee, will inspect all resident rooms to ensure there is a working nurse call bell present by May 5, 2025. 3. RCA: Nursing staff state they did not think resident could use call bell, so they	5/10/25

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 03/26/2025

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
F 919	Continued From page 114 stage renal (kidney) disease. 11/13/23 - R17's admitting MDS score was 00 for ADL's, meaning he was completely dependent for care by the facility. 3/6/25 10:05 AM - The surveyor observed that R17 did not have a call bell available in his room. 3/7/25 12:00 PM - The surveyor observed that R17 did not have a call bell available in his room. 3/10/25 1:40 PM - The surveyor observed that R17 did not have a call bell available in his room. The facility failed to provide R17 a call bell in three out of three observations. 3/10/25 1:44 PM - During an interview, E13 (CNA) stated that R17 previously had a touch call bell, but it was removed because it was not functioning properly. 3/10/25 3:18 PM - During an interview, E1 (CEO/LNHA) stated that a maintenance request for a new call bell was submitted after the Surveyor brought the lack of a call bell to her attention. 3/10/25 3:37 PM - The Maintenance staff installed a new touch call bell in R17's room. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 (SD/ICP) and nine department managers/representatives.	F 919	did not have the call bell replaced in the room. For R17, a flat call bell was replaced on 3/10/25 by maintenance. A therapy assessment was ordered and completed by OT on 4/24/25 and determined R17 is able to follow instruction to press the flat call bell for assistance, however, R17 occasionally presses the call bell with no needs required. Nursing staff were educated by OT on proper placement of flat call bell for R17 on 4/24/25. However, due to R17□s inconsistency with ability to utilize call bell only when needed, nursing instituted every 2-hour resident care checks for incontinence care, discomfort, and safety. If a resident has a MDS score of 00 for their ADL□s, a therapy order will be requested in the EMR and a paper referral form will be given to Therapy, and documented in the chart, with any suggestions for alternative interventions, such as more frequent rounding, toileting rounds, etc. Staff Development nurse, or designee, will educate professional nursing staff and therapy department on new process. 4. DON (or designee) will conduct audits of residents with MDS score of 00 for ADL's daily x 3 to ensure call bell is in place, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100%	

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 03/26/2025

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
F 919	Continued From page 115	F 919	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 940 SS=E	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.71. Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to implement and maintain an effective training program for new LPN staff regarding intravenous medication administration prior to being assigned to independently provide this service to R68 on 2/11/25. Findings include: Cross refer F726, example 2 and F760, example 1 Review of R68's clinical record revealed: 3/17/25 1:34 PM - During an interview, E14 (LPN), who was a new nurse and was hired on 7/23/24, stated, "[On 2/11/25] I was pulled to the 400 unit. It was the first time that I worked there. I had never given an IVSS antibiotic before... I was not trained about IV (intravenous) antibiotics	F 940	1. Unable to correct in the past. E14□s IV competency was completed on 4/29/2025 by Staff Development nurse. 2. All residents receiving IVPB medications have potential to be affected. Staff Development nurse will audit licensed nursing staff for IVPB administration competencies. Those without IVPB competencies will be completed by 5/30/2025. 3. RCA: There was no IV competency. Additionally, there was no standard process to ensure all competencies were completed on hire and annually and then filed properly. All licensed staff will complete competencies during orientation and Annual Skills fair in May of each year	5/10/25

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 03/26/2025

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
F 940	Continued From page 116 during orientation because we did not have anyone in the building with IV antibiotics...". 3/20/25 1:45 PM - Review of the Facility Assessment (dated Aug 2024) revealed that administration of IV medication (page 12 of the Facility Assessment) occurs in only 0.5% of their admissions/stays, which is very low relative to the benchmark. The Facility Assessment (page 26) also documented that the Staff training/Competencies/Skills in the area of IV medication was insufficient and an Action Plan was in place. It should be noted that this IVSS medication error occurred seven months after the Facility Assessment had concluded that the staff skills with regard to IV medication was lacking and an Action Plan had been put into place. 3/21/25 10:10 AM - The facility provided copies of the new orientee skills checkoff packet, which contained a skills checkoff for "Medication Administration: Intravenous". 3/21/25 3:45 PM - During an interview, E3 (SD/ICP) confirmed that that the facility did not have a skills checkoff for "Medication Administration: Intravenous" for E14. The facility was unable to provide evidence of a training process for new staff to learn the skills necessary to care for a resident that requires IVSS medication administration when there are no residents in house with this need. The facility did not provide any information regarding the Action Plan for IV Medication that was referenced in the Facility Assessment.	F 940	and the competency will be placed in their education file. The facility created an IV competency. The Staff Developer shall ensure that all licensed nurses complete their IV competency during the annual skills fair in May and subsequently on an annual basis. Furthermore, the IV competency has been incorporated into the new hire orientation skills checklist packet for licensed nurses during their floor orientation. 4. Staff Development nurse, or designee, will conduct audits of new nursing employees weekly x 3 to ensure they have completed IV competencies, 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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 03/26/2025

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
F 940	Continued From page 117 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 and nine department managers/representatives.	F 940		