

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Wilmington Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Foulk Road Wilmington, DE 19803	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0635</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide doctor's orders for the resident's immediate care at the time the resident was admitted.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that for one (R150) out of one resident reviewed for admission orders, the facility failed to ensure wound treatment orders were entered. Findings include: Review of R150's clinical records revealed:9/16/25 - R150 was readmitted to the facility with diagnoses including diabetes mellitus, congestive heart failure, and epilepsy.9/19/25 - A readmission Wounds Assessment Report for R150 completed by P1 (NP) documented treatment orders for four wounds, noted as present on admission.9/22/25 3:30 PM - Review of R150's clinical record revealed no current orders for wound care.9/24/25 2:15 PM - During an interview, the Surveyor asked E14 (RN) if R150 had treatment orders for wound care since he was readmitted on [DATE]. E14 stated, I don't see the orders, but I have been doing his wound care and dressing changes. 9/24/25 3:00 PM - During an interview E14 (RN) stated, Orders were put in today for dressing changes to begin tomorrow. 9/26/25 2:49 PM - Findings were reviewed with E1 (NHA).9/29/25 1:25 PM - Findings were reviewed with E1, E2 (DON) and E3 (Corporate Nurse) during the exit conference.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p>Based on record review and interview, it was determined that for one (R149) out of nine residents reviewed for activities of daily living the facility failed to ensure documentation regarding urostomy and pelvic drain output was recorded as ordered. Findings include: Review of R149's clinical record revealed:7/22/25 - R149 was admitted to the facility with a history of bladder cancer and recent urinary tract infection, pelvic infection a urostomy and pelvic drain. 7/22/25 - A physician's order was written for R149's pelvic drains to be emptied and the drainage amounts to be recorded.7/22/25 - A care plan was created for R149's care of urostomy that included the intervention to empty the urostomy drainage bag and change it as needed and record the amount [ML's].7/23/25 - A care plan was created for R149's care of pelvic drains that included the intervention to empty the pelvic drain as ordered. 7/29/25 - A physician's order was written for R149 that directed staff to empty the urostomy drainage bag and record the amount every shift. August 2025 - Review of R149's TAR lacked evidence that staff documented the amount drained from R149's urostomy; the slots were blank on the following dates: 8/3 7:15 AM 8/4 11:15 PM 8/6 3:15 PM 8/8 3:15 PM 8/13 3:15 PM 8/18 7:15 AM 8/19 7:15 AM August 2025 - Review of R149's TAR lacked evidence that staff documented the amount drained from R149's pelvic drains; the slots were blank on the following dates: 8/3 7:15 AM8/4 11:15 PM8/13 3:15 PM 9/24/2512:38 PM - During an interview, E40 (LPN) confirmed the findings. E40 stated, I believe the CNAs were allowed to drain them. If they drained the urostomy without telling me, they emptied it, I wouldn't know the amount to record.9/29/25 1:25 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on observation, interview and record review, it was determined that for two (R11 and R143) out of three sampled residents reviewed for nutrition, the facility failed to maintain acceptable parameters of nutrition and/or hydration. Findings include:Cross refer F677</p> <p>1.Review of R11's clinical records revealed:</p> <p>A facility policy titled, Weight Monitoring and Tracking, dated 1/29/24, documented, Procedure.2. Patients will be weighed on admission/re-admission and weekly x 4 weeks thereafter, or until the Interdisciplinary Team determines weight is stable, then monthly thereafter 6. Weekly weights should continue greater than 4 weeks if one or more of the following criteria are met: Significant unplanned weight change, Identified trends in weight change.Patients < (less) 100 pounds.8. The team will notify the provider and responsible party of significant weight changes.</p> <p>A. Weight Monitoring</p> <p>5/8/25 &ndash; R11 was re-admitted to the facility with diagnoses including chronic wounds, diabetes, dementia, acute kidney injury and moderate protein calorie malnutrition.</p> <p>5/8/25 &ndash; An OT (Occupational Therapy) evaluation documented that R11 was dependent with eating.</p> <p>5/9/25 &ndash; R11 was care planned for risk for protein calorie malnutrition and interventions included limited to obtain weights as ordered.</p> <p>5/12/25 &ndash; A nutrition assessment documented R11's most recent weight, obtained on 5/7/25, at 80.8 lbs.</p> <p>5/13/25 &ndash; A physician encounter note documented, Patient requires assistance with ADLs . staff working to encourage p.o. (by mouth) intake and maintain hydration and continue to monitor.</p> <p>6/1/25 4:03 PM &ndash; A nurse progress note documented, [R11] .(sic) 0-25 percent of her meal today. pocketing food in her mouth.</p> <p>6/3/25 &ndash; A physician's 30 &ndash; Day visit encounter note for R11 documented, . Patient with dysphagia pureed texture diet with nectar thick liquids and typically relies on staff .</p> <p>6/3/25 &ndash; R11 had an order for monthly weights. The order was discontinued on an unknown date.</p> <p>6/12/25 7:31 PM &ndash; A nurse progress note documented, [R11] continues with poor p.o. (per orem or by mouth) intake.</p> <p>6/23/25 &ndash; A physician's encounter note documented, Wt (weight): 80.8 lbs (from 5/7/25 record). nursing reports .decreased appetite over the weekend. ill initiate hypodermoclysis. staff to encourage p.o. intake and continue to monitor clinically.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6/24/25 &ndash; R11's nutrition assessment by E34 (RD) documented R11's most recent weight at 80.8 lbs. per record dated 5/7/25.</p> <p>6/30/25 &ndash; R11's annual MDS assessment revealed that R11's cognition was moderately impaired, R11 was dependent with eating and required the assistance of 2 or more helpers to complete the activity. R11 was on a mechanically altered diabetic diet. There was a lack of information on R11's weight during the review period.</p> <p>7/1/25 &ndash; A physician's encounter note documented, Wt: 80.8 lbs (from 5/7/25 record) . Acute kidney injury.I am told that p.o. intake has improved and staff working with the resident.</p> <p>9/8/25 &ndash; R11 had a physician's order for monthly weights.</p> <p>9/28/25 &ndash; A review of R11's weights revealed the following:</p> <ul style="list-style-type: none"> - 5/7/25 &ndash; 80.8 lbs. - 7/3/25 &ndash; 62.0 lbs. <p>9/29/25 11:20 AM &ndash; In an interview, E2 (DON) stated that E34 (RD) works part time and E2 thinks that E34 assessed R11 in person when completing the nutritional assessments and notes. E2 further confirmed that they (facility) don't have R11's June 2025 weight information. We could not find it. When asked if R11's weight was monitored when it started to decline after 5/7/25, E2 responded and confirmed, No.</p> <p>9/29/25 11/30 AM &ndash; In an interview, E10 (RN MDS) stated that, E27 (RN MDS) completed the nutritional status of R11's 6/30/25 quarterly MDS. E10 further stated that there was no information on R11's weight during the review period. E10 also confirmed and stated, A reweight should have been done for R11 since the last weight on record which was 80.8 lbs on 5/7/25 was taken more than 30 days prior to the assessment reference date.</p> <p>R11 had a 23.3% weight loss in 57 days, from 5/7/25 through 7/3/25. The facility policy was not adhered to when weights were not obtained for R11 when she weighed below 80.8 lbs at readmission through 7/3/25. R11's weight was not obtained after the nutrition assessment was completed on 6/24/25 by E34 (RD), who documented R11's weight at 80.8 lbs based on the 5/7/25 record. In addition, R11's weight was not obtained when R11's previous recorded weight was obtained more than 30 days prior to E27 (MDS Coordinator) assessment reference date.</p> <p>B. Diet Order</p> <p>6/28/20 &ndash; R11's original admission to the facility with diagnoses including difficulty swallowing following a stroke.</p> <p>10/8/24 &ndash; R11 had a physician's order for dysphagia pureed texture, nectar thick liquid consistency, no straws, double entr&eacute;e and divided plate. This order was discontinued on an unknown date.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5/8/25 &ndash; R11 had a physician's order for diabetic diet dysphagia (difficulty swallowing) mechanically altered, pureed texture (require change in texture of food or liquids ex. pureed food, thickened liquids), nectar thick liquid consistency, VEGETARIAN &ndash; NO BEEF/NO EGGS/NO POULTRY/NO PORK. Said physician's order was discontinued on an unknown date.</p> <p>8/12/25 &ndash; A dietary weight change note documented, [R11] has experienced a weight change. She continues to receive a Regular (sic), dysphagia puree with NTL (nectar thick liquid) w/ (with) VEGETARIAN &ndash; NO BEEF/ NO EGGS/ NO POULTRY/ NO PORK. Current intake is now mostly 0-50% of meals. [R11] is also receiving Magic cup TID (three times a day) in which she consumes mostly 100% .</p> <p>8/19/25 1:23 PM &ndash; A nurse progress note documented, This nurse . (dietitian), and (NP), had a conversation with [FM2, R11's daughter] with concerns of hydration and nutrition informed [sic] her resident presents with lack of desire to eating [sic] or drink. The dietitian went over possible nutrition considerations such as artificial nutrition (sic) the NP went over current code status (sic) the resident's daughter said she needs time to make the decisions and she will talk to [R11] tomorrow on a video call and follow up next week.</p> <p>9/8/25 &ndash; R11 was readmitted to the facility with diagnoses including UTI (urinary tract infection) and low blood sugar.</p> <p>9/8/25 &ndash; R11 had a physician's order for regular diet, dysphagia pureed texture, nectar thick liquid consistency.</p> <p>9/10/25 &ndash; R11 had a physician's order for magic cup three times a day with all meals related to severe protein calorie malnutrition. Said physician's order was discontinued on an unknown date.</p> <p>9/15/25 &ndash; R11's quarterly MDS assessment revealed that R11's cognition was severely impaired, had poor appetite nearly every day during the review period, was dependent with eating and required the assistance of 2 or more people to complete the activity. R11 had a 5% or more weight loss in the last month or loss of 10% or more in the last 6 months. R11 was also on a mechanically altered diet.</p> <p>9/26/25 12:55 PM &ndash; During lunch observation, R11's food tray was observed to contain the following: a single serving of regular pureed vegetable on a divided plate, a cup of nectar thickened cranberry juice and magic cup.</p> <p>9/26/25 1:00 PM &ndash; A review of R11's meal ticket tray notes/instructions revealed, double entr&ecute;e vegetarian no meat no eggs . water nectar 80z and magic cup.</p> <p>9/26/25 1:05 PM &ndash; When asked to clarify R11's dietary orders, E5 (LPN/UM) stated that R11 was vegetarian. E5 also confirmed that R11's divided plate contained single serving of the pureed vegetable. E5 left R11's room to clarify the orders with the kitchen staff.</p> <p>9/29/25 11:25 AM &ndash; When asked to clarify the conflicting active physician dietary orders regarding R11's portion serving size and vegetarian status as indicated in R11's meal tickets, E9 (RD) stated that R11 was to get a double a portion size and that kitchen staff will be educated on double portions and scooping instructions.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>9/29/25 11:27 AM &ndash; In a follow up interview regarding R11's vegetarian status, E9 stated that she had a meeting with R11's daughter [FM2]. E9 . The daughter was okay not to withhold R11's protein restrictions due to her very poor appetite and poor oral intake. E9 stated that R11's dietary orders will be clarified with the kitchen staff, and the meal ticket instructions will be updated.</p> <p>9/29/25 1:00 PM - Findings were discussed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse).</p> <p>9/29/25 1:25 PM - Findings were reviewed with E1, E2 and E3 during the exit conference.</p> <p>2. Review of R143's clinical record revealed:</p> <p>1/3/25 - A quarterly MDS assessment documented that R143 was severely cognitively impaired and dependent for eating.</p> <p>1/23/23 [last updated 2/28/24] - A care plan for risk of dehydration was created for R143. The goal of the care plan was to maintain adequate hydration. Additionally, a care plan for risk of constipation was created that included the intervention to encourage and assist as needed to consume fluids between meals. Lastly, a care plan for weight changes related to cognition was created that included an intervention to encourage and assist as needed to consume foods and/or supplements and fluids offered.</p> <p>January 2025 - Review of CNA documentation of PRN fluid intake lacked evidence that R143 was offered fluids or consumed fluids for seventeen day shifts, twenty-two evening shifts and twenty-four night shifts.</p> <p>February 2025 - Review of CNA documentation of PRN fluid intake lacked evidence that R143 was offered or consumed fluids for thirteen day shifts, sixteen evening shifts, and sixteen-night shifts.</p> <p>March 2025 - Review of CNA documentation of PRN fluid intake lacked evidence that R143 was offered or consumed fluids for eleven day shifts, three evening shifts, and three night shifts.</p> <p>9/26/25 11:41 AM - During an interview, E50 (CNA) stated that residents should be offered fluids, At least once [a shift] with the water cups and that intake of offered fluids is documented, On the task point of care, even if it's zero.</p> <p>9/26/25 11:44 AM - During an interview, E49 (CNA) stated that residents should be offered fluids, Throughout the day and that offering and consumption is documented, In the computer.</p> <p>9/26/25 11:45 AM - During an interview, E32 (CNA) stated that residents should be offered fluids, Three times a day and the resident response to being offered additional fluids is documented, on the computer.</p> <p>9/26/25 12:05 PM - During an interview, E5 (LPN) and the unit manager confirmed the finding and stated that fluids should be offered, At least twice a shift, meals and as needed. E5 confirmed that fluids offered and consumed are to be documented on the point of care documentation by the CNAs.</p> <p>9/29/25 1:25 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference.</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>Based on record review and interview, it was determined that for one (R149) out of one resident reviewed for change in condition, the facility failed to ensure ordered labs were completed timely. Findings include: The facility policy on laboratory and diagnostic testing last updated 1/29/24 indicated, Laboratory, radiology and other diagnostic services are provided to the center by way of written contractual agreements. The contracted service vendor is to provide services to the center that ensure safe and effective patient testing and timely delivery of results. Review of R149's clinical record revealed: 7/22/25 - R149 was admitted to the facility with a urostomy tube. 7/28/25 - A physician's order was written for R149 to receive urinalysis culture and sensitivity testing for recurrent UTIs and blood in the urine. 7/28/25 8:59 pm - A progress note in R149's clinical record documented, resident noted with some reddish urine in her urostomy bag. [MD] notified new order for urinalysis culture and sensitivity to rule out UTI. 7/29/25 - Review of the facility lab tracking form documented that R149's UA/C&S was to be collected that day. 7/30/25 - R149's lab results report documented that the UA/C&S was collected. Review of progress notes lacked clarification on why the urine sample was not collected on 7/28/25. 7/31/25 - A physician's order was written for R149 to receive an antibiotic medication for treatment of a UTI. 9/24/25 12:45 PM - During an interview, E41 (RN) and the unit manager on R149's unit confirmed that R149's urinalysis labs were not obtained timely. E41 stated, The doctor puts the order in and then we put it right to the lab book and most are done overnight shift. We put it in the book but usually during the same shift. 9/29/25 1:25 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, it was determined that for two (R150 and R35) out of five residents reviewed for infection control, the facility failed to initiate and maintain Enhanced Barrier Precautions (EBP) for contact with a resident with wounds and an indwelling medical device and failed to use appropriate disinfection practices. Also, the facility failed to prevent the risk of exposure to infectious and communicable diseases by not safely disposing a full sharps container. Findings include: An infection prevention and control facility policy titled, Standards of Practice dated, 2/6/20, documented, . Procedure 8 Environmental Cleaning/Disinfection: . DO NOT USE Alcohol based- disinfectants; alcohol-based disinfectants are not effective against C. difficile and should not be used to disinfect environmental surfaces.</p> <p>Review of R35's clinical records revealed:</p> <p>9/20/25 &ndash; R35 had a physician's order for contact precautions for C-diff (bacterial overgrowth that releases toxins that attack the lining of the intestines).</p> <p>9/22/25 11:00 AM - The Surveyor observed a notice of contact precaution outside of R35's room.</p> <p>9/22/25 11:01 AM - During interview, E26 (LPN) stated that R35 tested positive for C-diff the past weekend.</p> <p>9/22/25 11:02 AM - In an interview, R35 stated, I have been having diarrhea over the weekend. R35 was observed moving her over bed table and touching her call bell button. R35 was also observed and was heard asking E26 (LPN) to give her the bed control.</p> <p>9/22/25 11:03 AM &ndash; In an interview while in R35's room, E26 was asked what she uses to disinfect high contact objects such as doorknobs, bed rails, overbed tables, bed control and call light button. E26 pointed to the anti-bacterial alcohol-based hand sanitizer mounted on the wall. On her way out of E35's room into the hallway, E26 was heard instructing E32 (CNA) to show to the Surveyor the disinfectant being used.</p> <p>9/22/25 11:04 AM &ndash; In an interview, E32 (CNA) told the Surveyor that they (staff) have been using the anti-bacterial hand sanitizer. When the Surveyor asked E32 for the specific germicidal bleach wipes that targets the C-diff spores, E32 walked towards E38 (Central Supply staff), who confirmed that the facility has the germicidal bleach wipes in stock and that she was going to get it from her office.</p> <p>9/22/25 11:05 AM &ndash; E26 and E32 presented to Surveyor an unopened canister of germicidal bleach wipes. E26 told Surveyor she would use it to disinfect R35's room.</p> <p>2. CDC (Centers for Disease Control and Prevention) guidance dated 6/28/24, states, Enhanced Barrier Precautions are an infection control intervention designed to reduce the transmission of multidrug resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility policy titled Enhanced Barrier Precautions (EBPs) dated 3/26/24 states, .Procedure .1. [EBP] may be indicated for patients: With chronic wounds (.diabetic ulcers, vascular/arterial ulcers .) 4. Post Enhanced Barrier Precaution signage on the wall outside the patient(s) room. 5. Ensure PPE is available .</p> <p>Review of R150's clinical record revealed:</p> <p>8/2/25- R150 was readmitted to the facility with diagnoses including diabetes mellitus, congestive heart failure and epilepsy.</p> <p>8/11/25 - A Wound Assessment report completed by P1 documented R150 had two venous ulcers and a diabetic foot ulcer.</p> <p>8/26/25 - R150 was discharged from the facility.</p> <p>9/16/25 - R150 was readmitted to the facility.</p> <p>9/19/25 - R150 had a midline catheter placed for medication administration.</p> <p>9/22/25 - Enhanced Barrier Precautions (EBP) were ordered for R150 for midline catheter placement. This order was entered two days after R150 had midline catheter placed.</p> <p>9/22/25 3:19 PM - EBP signage was posted for R150 and PPE supplies were observed.</p> <p>9/24/25 - R150's midline catheter was removed.</p> <p>9/25/25 2:30 PM - No EBP signage or PPE supplies were observed for R150.</p> <p>9/26/25 1:20 PM - No EBP signage or PPE supplies were observed for R150.</p> <p>9/26/25 1:52 PM - During an interview, The Surveyor asked E11 (IP) if EBP is required for residents that have chronic wounds. E11 stated, EBP should be in place.</p> <p>3. The OSHA (Occupational Safety and Health Administration) Bloodborne Pathogens Standard 29 CFR 1910.1030.(d)(4)(iii)(A)(2)(iii), which describes safeguards to prevent needlestick injuries and protect employees from occupational hazards associated with bloodborne pathogens, states, .containers for sharps shall be routinely replaced and not be allowed to overfill.</p> <p>FDA (U.S. Food and Drug Administration) April 2021 guidance states, .sharps disposal containers are marked with a line to indicate when about three-fourths (3/4) full .sharps disposal containers in healthcare facilities should be disposed when three fourths (3/4) full .</p> <p>9/22/25 2:15 PM - A full sharps container was observed in a residential bathroom in the Memory Care unit.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Wilmington Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Foulk Road Wilmington, DE 19803	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>9/22/25 3:04 PM - E39 (LPN, UM) confirmed the full sharps container in the residential bathroom. During an interview, E39 stated, The sharps containers are replaced when they are full. I will let someone know the container needs to be changed.</p> <p>9/24/25 9:16 AM - A full sharps container was observed in the same residential bathroom.</p> <p>9/25/25 2:25 PM - E5 (LPN, UM) confirmed the full sharps container in the same resident bathroom. E5 stated, I will change it now.</p> <p>9/29/25 1:25 PM - Findings were reviewed with E1, E2 (DON) and E3 (Corporate Nurse) during the exit conference.</p>