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	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kutz Rehabilitation and Nursing	704 River Road Wilmington, DE 19809

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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview, record review, and review of other facility documents, it was determined for one (R10) out of three residents reviewed for abuse, the facility failed to ensure that R10 was free from verbal abuse from a staff member. Findings included: 12/2017 - A facility document entitled, Resident Abuse Prevention, Protection, Identification, Suspected Crime, Incident Reporting and Investigation Policies and Procedures, revised 12/2022, 12/2023, 3/2024, 3/2025, and 5/2025 included, The facility will prohibit, prevent and not tolerate residents to be subjected to abuse.by anyone, including staff members.R10's clinical record revealed:1/10/25 - R10 was admitted to the facility with diagnoses, including but not limited to, cancer of the rectum. 7/15/25 - R10's quarterly MDS assessment documented a BIMS score of 15, indicating a fully intact cognitive status. R10's MDS also documented that he was independent for ambulation with a rolling walker.9/10/25 5:54 PM - A facility reported incident submitted to the State Survey Agency documented, Resident [R10] reported to [E6] (SSD) that on 8/22/25 during the 11 PM to 7 AM shift he went outside off campus to smoke and when he returned to the facility and started walking toward the [unit number] nursing station and he had an encounter with [E7] (RN.) Per R10, E7 stated, [R10] when I am here on the night shift, you are not allowed to [expletive] go outside. E10 reported that he replied, I don't know who the [expletive] you are talking to, but you can't talk to me like a piece of [expletive.] R7 replied, If you go out that door, I am telling the staff not to buzz you back in.9/16/25 - The facility's 5-day follow up report submitted to the State Survey Agency documented that based on the facility's investigation and review of video camera recording the allegation of verbal was substantiated and E7 was terminated.2/26/26 9:00 AM - During a telephone interview, E9 (CNA) stated, The nurse [E7] was upset that night because she was called to come into work. I saw and heard her talking to the resident [R10] loudly about his smoking. She also used curse words at him when he answered her back. The Surveyor asked E9 why this incident was not reported to the facility's administration right away. E9 stated, It was during the night shift and she [E7] was the supervisor.2/26/26 9:30 AM - During a telephone interview, E8 (RN) stated, I saw the nurse talking to the resident, but I was too far away to hear what they were saying.2/26/26 10:00 AM - During a telephone interview, E7 stated, I was the on-call nurse, and I was called to come into work. I spoke to the resident about going out to smoke, but I don't recall cursing at him.2/26/26 11:00 AM - During an interview, the Surveyor asked E1 (NHA) about why the incident report was submitted to the State Agency on 9/10/26 when the resident reported the incident on 8/23/25. E1 stated, We thought it was more like a grievance and were investigating it that way. When we realized that it was actually a reportable incident, we reported it right away.2/26/26 1:30 PM - The facility provided the Surveyor with abuse prevention and resident protection education that was provided to the staff. During a combined interview, E14 (CNA), E15 (LPN), E17 (CNA), E20 (CNA) and E21 (CNA) confirmed that they received education and training on abuse prevention. Based on review of the facility corrective actions, interview with staff members and no further episodes of abuse, this deficient practice is considered past non-compliance with a correction date of 9/12/25.2/26/26 2:00 PM - Findings were confirmed with E1 and E2 (DON.) 3/4/26 3:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.

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

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	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kutz Rehabilitation and Nursing	704 River Road Wilmington, DE 19809

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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview and record reviews, it was determined that for two (R16 and R79) out of six residents reviewed for ADLs (Activities of Daily Living), the facility failed to ensure each dependent resident received the necessary services to maintain grooming and personal hygiene. For R16, the facility failed to provide incontinence care during the evening shift when her clothes and linens were found saturated with urine. For R79, the facility failed to ensure that R79's morning care was done when he was found wearing his pajamas in the afternoon. Findings include: 1. Review of R16's clinical record revealed:6/19/24 - R16 was admitted to the facility with diagnoses including dementia.7/24/24 - R16 was care planned for impaired thought processes related to dementia.10/30/24 - R16 was care planned for ADL self-care performance deficit related to osteoarthritis and dementia with interventions including partial to substantial assistance of one person for personal and oral care and scheduled toileting every 2 hours. R16 required one staff person for toileting and required partial assistance of one person staff to move between surfaces and as necessary.8/6/25 - A quarterly MDS (Minimum Data Set) assessment revealed that R16's cognition was moderately impaired with a BIMS score of 9. R16 dependent with toileting and required substantial/maximal assist with personal hygiene and upper and lower body dressing. R16 who required partial, moderate assistance with toilet transfer was frequently incontinent of bowel and bladder.8/19/25 - R16's August 2025 CNA (Certified Nurse Assistant) Documentation Survey Report revealed that on 8/19/25 during the 3-11 shift, E14 (CNA), the assigned CNA for R16 documented N/A or Not Applicable for R16's toileting schedule for 3-11 shift at 4:00 PM, 6:00 PM, 8:00 PM and 10:00 PM. 8/19/25 - A facility incident report submitted to the state agency revealed that E14 failed to provide incontinence care to R16 on the 3-11 shift. 8/22/25 - A Facility 5-day follow up summary report documented, [R16's] clothing and linen was observed by oncoming 11-7 am shift saturated with urine. E28 [LPN] from 3-11 pm shift confirmed findings when notified. CNA [E14] responsible for the for 3-11 pm care of [R16] states [R16] was resistant to care assist during shift, however E28 [LPN] nor E27 [RN] were notified to possibly provide assistance or documentation. Resident care was provided by oncoming shift CNA [E9]. Unable to prove resident care was given during shift to combat allegation . 3/3/25 1:48 PM - In a telephone interview, E9 confirmed and stated, I went to do my rounds and saw [R16's] clothing and linen saturated and soaked with urine. Her bed mattress was also wet. I cleaned and changed [R16] and I also cleaned and wiped her bed. I notified the nurse of the incident.3/3/26 3:00 PM - Finding was discussed with E2 (DON).2. Review of R79's clinical record revealed: 6/18/25 - R79 was admitted to the facility with diagnoses including dementia, stroke and weakness.6/27/25 - An admission MDS (Minimum Data Sheet) assessment revealed that R79's cognition was moderately impaired with a BIMS score of 11. R79 required setup or clean - up assistance with eating, partial/moderate assistance with oral hygiene and upper body dressing. R79 required substantial/maximal assistance with toileting, shower/bathing, lower body dressing and personal hygiene. 6/27/25 (revised 7/23/25) - R79's was care planned for ADL self - care deficit and interventions included but not limited to partial assistance by one staff person for dressing, partial to substantial assistance with personal hygiene and oral care and substantial assistance for toileting.8/4/25 3:11 PM - A facility incident report submitted to the state agency documented that R79's daughter in law [FM1] approached E22 (LSW) because [FM1] did not believe [R79] had received morning care. [R79] was still in his pajamas in bed when [FM1] arrived and [R79] had yet to receive his lunch tray.8/4/25 - A written statement by E16 (CNA) documented that between 8:30 AM and 9:30 AM R79 was eating breakfast. At 10:00 AM, E16 found R79 asleep in bed. At 12:55 PM, E26 (RN Sup) paged E16 and questioned if E16 had missed or had performed care on R79.8/4/25 2:59 PM - R79's August 2025 CNA (Certified Nurse Assistant) Documentation Survey Report revealed that on 8/4/25 on the 7-3 shift, R79's dressing task was marked completed by E16. 8/11/25 - A facility follow up summary documented that R79 was assigned to E16 during the 7-3 shift on 8/4/25. E16 (continued on next page)

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	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kutz Rehabilitation and Nursing	704 River Road Wilmington, DE 19809

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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed that care was not provided to R79 prior to E26 questioning her.3/3/26 9:48 AM - In an interview, E22 stated that FM1 came to see her around 3:00 PM on 8/4/25 to report that R79's morning care was not done as he was still wearing his pajamas. She also confirmed that . Only after the family reported to me, and I notified the nurse, then the CNA changed [R79].3/3/26 1:55 PM - During a telephone interview, E16 confirmed that she was only able to change and provide care to R79 in the afternoon after she was called by E26. 3/3/26 3:35 PM - Finding was discussed with E2 (DON).3/4/26 3:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.

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	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kutz Rehabilitation and Nursing	704 River Road Wilmington, DE 19809

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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, it was determined for one (R81) out of three residents reviewed for accidents, the facility failed to ensure that R81 received adequate supervision and assistance to prevent accidents to the extent possible. Findings include: 3/17 - A facility document entitled, Falls, revised 2/25 and 3/25, included, To institute individualized practices to minimize the resident's risk of falling and to maximize safety from falls .High Risk - a Fall Risk Evaluation score of 6 or greater.R81's clinical record revealed: 1/17/18 - R81 was admitted to the facility with diagnoses including, but not limited, to left side weakness after a stroke. 2/6/18 - R81's care plan for bed mobility included, Extensive - total dependence, support of two persons. 5/26/25 - R81's fall risk evaluation documented a score of 10, indicating a high fall risk. 5/28/25 - R81's quarterly MDS assessment documented a BIMS score which indicated an inability to participate in a cognitive assessment. The MDS also documented that R81 was completely dependent on the staff for all activities of daily living. 8/22/25 8:30 PM - A facility reported incident report submitted to the Division included, At 1730 [5:30 PM] during peri care from his aid, the resident was turned on to his side and fell from the bed to the floor. The resident suffered head trauma and is on blood thinners .the resident was sent to the ER [Emergency Room] for evaluation .8/23/26 4:00 AM - R81 returned to the facility from the ER. The ER report included, .A small laceration on the top of your scalp, this has been fixed by tying a knot with your hair to bring the edges of the laceration together and securing it with some glue.2/26/26 10:00 AM - The Surveyor attempted to call the staff member who took care of the resident when the fall occurred. The phone call was not answered. During an interview, E1 (NHA) stated that education on safe patient handling was provided to the aide. The Surveyor asked education was provided to other staff member. E1 stated, No.2/26/26 11:10 AM - A review of the facility's corrective action after the fall revealed that the staff member who provided care for R81 during the fall received education on fall prevention. The facility lacked evidence that timely education for other staff members who provide care was provided.2/26/26 2:20 PM - Findings were confirmed with E1 (NHA) and E2 (DON.) 3/4/26 3:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.