

Office of Long Term Care Residents Page 1

Protection

STATE SURVEY REPORT

NAME OF FACILITY: Kutz Rehabilitation And Nursing

Regulations for Skilled and Intermediate Care Facilities Scope Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference. This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey F 880 A) Corrective action for the residents affected by the all deficient practice: of failing place the residents 6 feet are for social distancing during meal time during the COVI pandemic. During surveyor observation, residents were immediately moved to prove 6 feet of social distancing, some residents returned to the rooms. Portable Plexiglas shields were moved into the room to provide added protection for those resident remaining in the area. Dialogue with the investigation of the residents affected by the all deficient practice: of failing place the residents of feet are for social distancing during meal time during the COVI pandemic. During surveyor observation, residents were immediately moved to prove 6 feet of social distancing, some residents returned to the rooms. Portable Plexiglas shields were moved into the room to provide added protection for those resident remaining in the area.	SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
possible changes to ensure	3201 3201.1.0 3201.1.2	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced COVID-19 Focused Infection Control was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection, which began on January 20, 2021 and ended on January 22, 2021. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census on the first day of the survey was fifty six (56). The survey sample totaled ten (10). Regulations for Skilled and Intermediate Care Facilities Scope Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference. This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey	F 880 A) Corrective action for the residents affected by the alleged deficient practice: of failing to place the residents 6 feet apart for social distancing during meal time during the COVID 19 pandemic. During surveyor observation, residents were immediately moved to provide 6 feet of social distancing, with some residents returned to their rooms. Portable Plexiglas shields were moved into the room to provide added protection for those residents remaining in the area. Dialogue with the investigator took place for suggestions of	03/12/202



_Title__CEO______Date 1/11/2021____

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Office of Long Term Care
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STATE SURVEY REPORT

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NAME OF FACILITY: Kutz Rehabilitation And Nursing

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		There was no negative outcomes identified for any of the residents present during the alleged deficient practice.	
		B) All communal dining areas, utilized for residents requiring direct assistance with meals, were evaluated between 1/22/2021 and 1/25/2021 for an effective social distancing configuration. There were no negative outcomes identified for any other Kutz Rehabilitation and Nursing residents eating in these communal dining areas.	
		C) Immediately following the communal dining evaluations, corrective action was taken to address all possible deficient practices.	
		C.1) Furniture was removed or repositioned to assist with social distancing for all residents. C.1.a) A new seating arrangement in the Garden Room was initiated immediately after the survey, placing blue tape lines on the floor marking 6 feet distance to easily identify the appropriate social distancing for resident placement during meal	



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STATE SURVEY REPORT Page 3

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		observation.	
		C.1.b) Partitions were placed in all communal dining areas as an added safety measure to ensure separation of staff and residents during each shift, including meals.	
		C.1.c) Guidelines were established requiring no more than seven residents within the Garden Room at any one time to ensure adherence of 6 feet separation for effective social distancing. Only those residents assigned to the Garden Room may have meals, or activity time, in the Garden Room to ensure the number of residents present does not exceed 7 residents at any one time in the space.	
		C.2) Immediate verbal inservicing was done with the unit manager, charge nurses, and restorative staff present in the Garden room, and then later with all other nursing staff, in writing, on February 8 – 11, 2021 regarding implementation of a comprehensive plan to	
		of a comprehensive plan to ensure 6 feet social distancing.	
	Filiado E. Hal	C.2.a) Social distancing	



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NAME OF FACILITY: Kutz Rehabilitation And Nursing

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		guidelines will be included in the new hire orientation, and the yearly continued staff education plan regarding the definition, importance, and process of maintaining social distancing in any space throughout Kutz Rehabilitation and Nursing staff, and staff reassignments.	
		D). Monitoring for success D.1) All communal dining areas will be placed on 100% monitoring (see attached form) for strict adherence of 6 feet social distancing for all staff and residents as follows:	
		D.1.a) The monitoring will be performed daily until we consistently reach 100% success over 3 consecutive evaluations. THEN, D.1.b) The monitoring will be performed three times each week	
		times each week until we consistently reach 100% success over 3 consecutive	

Provider's Signature _	telisher E. Ald	TitleCEO	Date 1/11/2021
_			Datc 1/11/2021



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STATE SURVEY REPORT

NAME OF FACILITY: Kutz Rehabilitation And Nursing

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETIO DATE
		evaluations.	
		THEN,	
		D.1.c) The monitoring will	
		be performed once	
		per week until we	
		reach 100% success	
		over 3 consecutive	
		evaluations.	
		FINALLY,	
		D.1.d) The monitoring will	
		be performed one	
		more time, a month	
		later. If we remain	
		at 100% compliance,	
		we can conclude that	
		we have addressed	
		the opportunity.	
		D.2) The plan of correction for infection control for social distancing will be added to the QAPI monitoring plan with data presented at the February QAPI meeting.	
		D.2.a) Monitoring results will be reported at least quarterly to the QAPI team.	
		D.2.b) Results will also be reported to the Quality Assurance committee of the Kutz Senior Living Campus Board of Directors at their regular meetings.	



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NAME OF FACILITY: Kutz Rehabilitation And Nursing

DATE SURVEY COMPLETED: January 22, 2021

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE

STATE SURVEY REPORT

Provider's Signaturetuske L. XulTitleCEC	Date 1/11/2021
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PRINTED: 02/24/2021 **FORM APPROVED** OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
		085043	B. WING		01	/22/2021	
	PROVIDER OR SUPPLIER EHABILITATION AND I	NURSING		STREET ADDRESS, CITY, STATE, ZIP C 704 RIVER ROAD WILMINGTON, DE 19809			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 000	Control was conducted Division of Health Control Term Care Resident January 20, 2021 at 2021. The deficient are based on obsert clinical records and indicated. The facilithe survey was fifty totaled ten (10).	cOVID-19 Focused Infection cted by the State of Delaware care Quality, Office of Long ts Protection, which began on and ended on January 22, cies contained in this report vations, interviews, review of other documentation as ity census on the first day of six (56). The survey sample	FO	00			
	DON - Director of NED - Executive Dire LPN - Licensed Pra RN - Registered Nu CDC - Centers for E Prevention; CMS - Centers for NEOVID-19 (Coronal that can be spread Infection Prevention CFR(s): 483.80(a)(1) §483.80 Infection CFR facility must estimate the facility	ursing; ctor; ctical Nurse; rse; Disease Control and Medicare & Medicaid Services; virus) - a respiratory illness person to person. & Control 1)(2)(4)(e)(f) ontrol tablish and maintain an and control program a safe, sanitary and ment and to help prevent the ansmission of communicable	F 8	80 TITLE		3/12/21 (X6) DATE	

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.

Electronically Signed

02/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING		E SURVEY IPLETED
		085043	B. WING _		01/	22/2021
NAME OF PROVIDER OR SUPPLIER KUTZ REHABILITATION AND NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 704 RIVER ROAD WILMINGTON, DE 19809			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	program. The facility must es and control program a minimum, the foll §483.80(a)(1) A system or trends and communicable staff, volunteers, visproviding services arrangement based conducted accordinaccepted national signature of the but are not limited to (i) A system of survivial procedures for the but are not limited to (ii) When and to who communicable disereported; (iii) Standard and the to be followed to profit (iv) When and how it resident; including to (A) The type and dudepending upon the involved, and (B) A requirement the least restrictive positive circumstances. (v) The circumstances.	tablish an infection prevention in (IPCP) that must include, at owing elements: stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual I upon the facility assessment in the general standards; en standards, policies, and program, which must include, or eillance designed to identify able diseases or ey can spread to other ty; om possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a	F 88			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ELE CONSTRUCTION		E SURVEY PLETED
		085043	B. WING		01/2	22/2021
	PROVIDER OR SUPPLIER EHABILITATION AND	NURSING		STREET ADDRESS, CITY, STATE, ZIP CODE 704 RIVER ROAD WILMINGTON, DE 19809		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	BE	(X5) COMPLETION DATE
F 880	contact will transmi (vi)The hand hygier by staff involved in a §483.80(a)(4) A systidentified under the corrective actions to §483.80(e) Linens. Personnel must har transport linens so a infection. §483.80(f) Annual ratransport linens so a infection. For and update that the facility will condition to the consumentation one out of three dinfailed to ensure that COVID-19 during a residents were not a social distancing resix feet apart during include: Review of the CDC Control for Nursing 11/20/2020, indicate "Implement aggress measures (remaining others) https://www.cdc.gov.ong-term-care.html.	nts or their food, if direct to the disease; and he procedures to be followed direct resident contact. Item for recording incidents facility's IPCP and the aken by the facility. Indie, store, process, and has to prevent the spread of direct an annual review of its eir program, as necessary. IT is not met as evidenced hion, interviews, and review of in, it was determined that for ing areas observed, the facility it measures to prevent in outbreak were in place; seated in accordance with equirements of a minimum of a communal dining. Findings Is webpage for "Infection Homes", last updated and that facilities are to sive social distancing and at least 6 feet apart from a control of the c	F 880	F 880 A) Corrective action for the reside affected by the alleged deficient proof failing to place the residents 6 fe apart for social distancing during mime during the COVID 19 pandem During surveyor observation, reside were immediately moved to provide of social distancing, with some resireturned to their rooms. Portable Plexiglas shields were moved into the room to provide added protection for those residents remaining in the and Dialogue with the investigator took for suggestions of possible change ensure adequate social distancing small alternate dining areas. There no negative outcomes identified for the residents present during the alledeficient practice.	actice: et eal ic. ents e 6 feet dents the or ea. place s to in all was any of	

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F 880	observation of comadjacent to the 100 were observed sitti rectangular table. It seated next to each third resident was sidirectly across the was one over bed to During this same of (LPN) were seated ends of the table. Ewere seated less the During an interview (RN-Supervisor) cowere seated less the repositioning the redistancing. 1/10/21 12:45 PM - observed bringing to between residents of the table.	amunal dining in the lounge and 300 halls, three residents ing at a single six foot. Two of the residents were in other two feet apart and a seated three and a half feet table. In the same room there able that was not being used be be be servation, E5 (CNA) and E6 at the same table at opposite E5 confirmed that the residents in an six feet apart. If you 1/20/21 at 12:25 PM, E4 and firmed that the residents in an six feet apart and began is idents to adhere to social. E1 (ED) and E2 (DON) were two plastic partitions to place.	F 880	B) All communal dining areas, ut residents requiring direct assistant meals, were evaluated between 1/2 and 1/25/2021 for an effective sood distancing configuration. There we negative outcomes identified for a Kutz Rehabilitation and Nursing releating in these communal dining as C) Immediately following the communing evaluations, corrective action taken to address all possible deficit practices. C.1) Furniture was removed or repositioned to assist with social distancing for all residents. C.1.a) A new seating arrangement Garden Room was initiated immediater the survey, placing blue tape the floor marking 6 feet distance to identify the appropriate social distance for resident placement during meas activities, and observation. C.1.b) Partitions were placed in all communal dining areas as an addisafety measure to ensure separatistaff and residents during each shincluding meals. C.1.c) Guidelines were established requiring no more than seven residenting the many on to ensure adherence of 6 feet separation of the Garden Room at any on to ensure adherence of 6 feet separation of the Garden Room to ensure the number sidents present does not exceed the feather than the Garden Room to ensure the number sidents present does not exceed the feather than the Garden Room to ensure the number sidents present does not exceed the feather than the feather t	ce with 22/2021 ial ere no ny other sidents reas. munal n was ent in the liately lines on o easily incing I times, et ime aration of the eration of the eration of the er of		

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F 880	Continued From pa	ge 4	F 880	residents at any one time in the specific consistently reach 100% success over 3 consecutive evaluations. THEN, D.1.c) The monitoring will be perfonce per week until we consistently reach 100% success over 3 consecutive evaluations. The Monitoring will be perfonce per week until we consistently reach 100% success over 3 consecutive evaluations. The monitoring will be perfonce per week until we reach 100% success over 3 consecutive evaluations. The monitoring will be perfonce per week until we reach 100% success over 3 consecutive evaluations. The monitoring will be perfonce per week until we reach 100% success over 3 consecutive evaluations. The monitoring will be perfonce per week until we reach 100% success over 3 consecutive evaluations. The monitoring will be perfonce per week until we reach 100% success over 3 consecutive evaluations. The monitoring will be perfonce per week until we reach 100% success over 3 consecutive evaluations. The perfonce per week until we reach 100% success over 3 consecutive evaluations. The perfonce per week until we reach 100% success over 3 consecutive evaluations. The perfonce per week until we reach 100% success over 3 consecutive evaluations. The perfonce per week until we reach 100% success over 3 consecutive evaluations. The perfonce per week until we reach 100% success over 3 consecutive evaluations. The perfonce per week until we reach 100% success over 3 consecutive evaluations. The perfonce per week until we reach 100% success over 3 consecutive evaluations.	ing was leent in the all other ry 8 or of a leet swill be an and ancing in illitation littached as social as as leading and ancing in illitation littached as social as as leading at leading and lea			

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A: BUILDING		(X3) DATE SURVEY COMPLETED			
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F 880	Continued From pa	ge 5	F 880	one more time, a month later. If w remain at 100% compliance, we calconclude that we have addressed opportunity. D.2) The plan of correction for it control for social distancing will be to the QAPI monitoring plan with dispresented at the February QAPI m D.2.a) Monitoring results will be repat least quarterly to the QAPI team D.2.b) Results will also be reported Quality Assurance committee of the Senior Living Campus Board of Direct at their regular meetings.	an the anded ata eeting. corted to the e Kutz			