| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **085001** | A. BUILDING _____ B. WING _____ | **10/13/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **KENTMERE REHABILITATION AND HEALTHCARE CENTER** | **1900 LOVERING AVENUE WILMINGTON, DE 19806** |

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 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review and interview, it was determined that for one (R1) out of four residents reviewed, the facility failed to identify a resident exhibiting a new onset of COVID-19 related symptoms and place the resident on Transmission-Based Precautions. Findings include: 5/13/2020 - The CDC website published Symptoms of Coronavirus. On the website, CDC stated, .People with these symptoms may have COVID-19: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea . R1's clinical record review revealed: 8/31/2020 - R1 was admitted to the facility for short-term rehabilitation and IV antibiotic administration. 9/11/2020 at 8:58 PM - A nurse's note stated that R1 was alert, oriented and able to make his needs known. R1 complained of a small cough. 9/14/2020 at 2:48 PM - A nurse's note stated that R1 was seen by E3 (NP) who ordered medication for R1's cough. 9/15/2020 - A physical therapy treatment note stated that R1 declined therapy due to a migraine headache. 9/16/2020 at 12:33 AM - A nurse's note stated that R1 was administered medication for his cough. 9/16/2020 - An occupational therapy note stated that R1 was too tired to complete therapy. 9/16/2020 - A physical therapy note stated that R1 was not feeling well and unable to participate further . 9/16/2020 - A specimen was collected from R1 for monthly surveillance COVID-19 testing. 9/18/2020 at 11:28 AM - A nurse's note stated that R1's COVID-19 lab result returned positive. 9/18/2020 at 9 PM - A physician progress notes [REDACTED]. 10/13/2020 at 2:50 PM - Findings were reviewed with E1 (NHA) and E2 (DON). |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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.