

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	X3) DATE SURVEY COMPLETED 12/10/2015
NAME OF PROVIDER OR SUPPLIER FORWOOD MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1912 MARSH ROAD WILMINGTON, DE 19810	
(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 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from December 4, 2015 through December 10, 2015. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 53. The Stage 2 survey sample size was 25.</p> <p>Abbreviations/definitions used in this 2567 are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RNAC - Registered Nurse Assessment Coordinator; RN - Registered Nurse; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; FMD - Facility Maintenance Director; ADL/ADLs - Activities of Daily Living; includes bathing, toilet use, and transfers; B&B - bowel and bladder; MAR - Medication Administration Record; MDS- Minimum Data Set (standardized assessment forms used in nursing homes); NAD - No Acute (sudden severe) Distress; NN's - nurse's notes; POS - physician order sheet; TAR- treatment administration record; Always Incontinent - no episodes of continent voiding; Antidepressant-drug to treat depression; Antipsychotic- class of medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality and other mental and emotional conditions;</p>	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____

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.

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F 000	Continued From page 1 Anxiety-general term for disorders that cause nervousness, fear and worrying; Antianxiety-drug used to treat anxiety; CHF - (congestive heart failure) - heart unable to pump enough blood to meet the body's needs; Cognitively Impaired - abnormal mental processes; thinking OR mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently; Continance - control of bladder function; Data Collection Tool - nursing assessment tool used to obtain medical history to assist with the plan of care; Depression - mental disorder with feelings of sadness or a mood disorder that causes a persistent feeling of sadness and loss of interest that affects how you feel, think and behave; Diabetes-blood sugar levels are too high; Digoxin- medication used to treat congestive heart failure; Digoxin level - a blood test that determines the level of the medication in your blood to ensure that you are not receiving too much or too little of the drug; Frequently Incontinent - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding; Incontinent/Incontinence - loss of control of bladder function; Psychiatric-(psych)-relating to mental illness or its treatment; q - every; mg - milligram; SBP- systolic blood pressure - the top number of the blood pressure reflects the pressure in the blood vessels when the heart is beating; UTI - urinary tract infection - bacteria in urine; Urinary Incontinence - inability to prevent	F 000			

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F 000	Continued From page 2 accidental leakage of urine from bladder; < - less than. 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 000			
F 253 SS=D	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior for one (room 137) out of 30 rooms reviewed. Findings include: During a Stage 1 observation on 12/4/15 at 2:30 PM, room 137B's call bell was observed to have a cracked button. This made it impossible for a resident to activate the call bell without using a lot of force or using a pointed object. Finding was reviewed with E13 (FMD) on 12/8/15 at 2:00 PM during the environmental tour and E13 confirmed the finding. Finding was reviewed with E1 (NHA) and E2 (DON) on 12/10/15 at approximately 3:00 PM. 483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 253	<ol style="list-style-type: none"> Room 137B call bell button was replaced immediately (12/04/2015) when the findings were reviewed by E13 (FMD). Residents have the potential to be effected by faulty call bell buttons. An audit was complete4d on all call bells in all resident rooms. No additional call bells needed to be replaced. It was determined that the call bell was not reported to be defective by staff. The nursing staff will be in-serviced by the NHA / designee to report observed defective call bells to the maintenance depart immediately. The maintenance staff will be in-service by the Director of engineering to repair call bell buttons and or cord as soon as possible when notified. Policies and procedures were reviewed and no revisions were necessary to achieve regulatory compliance. The Director of engineering will audit all call bells for functionality weekly times four weeks then monthly for one quarter. Defective calls bells will be replaced immediately. Audit findings will be reported during the monthly QAPI meeting. The QAPI committee will review outcomes and give recommendations as appropriate for improvement. Results thresholds are established at 100%. The frequency of the audits will be adjusted according to outcomes. 		
F272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 253		2/03/2015	

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F 272	<p>Continued From page 3</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and interviews, it was determined that the facility failed to <u>comprehensively and/or accurately assess three</u></p>	F 272	<ol style="list-style-type: none"> R8 resides in the Facility. The Annual MDS assessment for this resident has been modified and re-submitted with the appropriate coding that resident needs assistance for toileting. All residents could potentially have been affected by this practice. AN MDS review will be completed on all incontinent residents to ensure accuracy of coding on the MDS. It was determined that the MDS's for this resident was not coded appropriately. The MDS coordinator will be provided in-servicing on the importance of accurate MDS coding as it reflects the current status of the residents during the assessment period by the DON/designee. Policies and Procedures have been reviewed and no revisions were necessary to achieve regulatory compliance. The DON/designee will conduct a random audit on three new admits weekly to assure compliance with the accuracy of MDS assessments and coding. Results threshold are established at 100%. 		

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F 272	Continued From page 6 treated with an antibiotic. It was also unclear why the facility failed to identify that R30 was admitted on a medication, Oxybutynin, that was used to treat urinary incontinence. Further review of the 6/19/15 Bladder Incontinence Assessment revealed that the Summary section was blank, which lacked an analysis and recommendation on how to appropriately treat and provide services to restore as much normal bladder function as possible for R30. The facility failed to identify whether R30 was or was not recommended for a retraining program or chose not to participate in a program based on the comprehensive assessment. The facility failed to comprehensively assess R30 for urinary incontinence by failing to complete the bladder incontinence assessment and failing to complete the 3-day B&B flow sheet. In an interview on 12/10/15 at 10:33 AM, findings were reviewed with E2. The facility failed to comprehensively assess R30 for urinary incontinence.	F 272	3 It was determined that the facility failed to comprehensively assess the residents urinary incontinence and failed to complete the 3 day B&B flow sheet for this resident. An inservice will be done by the DON/designee with all nursing staff on the correct way to assess residents with urinary incontinence and the importance of following up with a B&B flow sheet. Policies and Procedures have been reviewed and no revisions were necessary to achieve regulatory compliance. 4. The DON/designee will conduct a random audit on 30% of new admits monthly who have urinary incontinence. The audit will determine that residents have been assessed for urinary incontinence appropriately on admission and will also ensure that a 3 day B&B flow sheet has been completed accurately. Results threshold are established at 100%. Findings will be reviewed with the NHA with corrective action as needed and reviewed during the QA+A committee meetings. The QA+A committee may adjust the frequency of the monitoring as it is deemed appropriate.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the	END F 272		2/03/15

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F 278	<p>Continued From page 7</p> <p>assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and interviews, it was determined that the facility failed to accurately assess two (R21 and R48) out of 25 Stage 2 sampled residents. The facility failed to accurately assess R21's dental status and they failed to accurately assess R48 in the area of medication usage. Findings include:</p> <p>1. On 11/19/15 a physician's order was written for R48 to take Trazadone (an antidepressant) at 3 PM and 9 PM for agitation and anxiety.</p> <p>The clinical record was absent of the November 2015 MAR and TAR.</p> <p>Review of the December MAR revealed that R48 received Trazadone as ordered on 12/1/15 and 12/2/15.</p>	F 278	<p>1. Resident R21 resides in the facility. The MDS's for this resident was modified and re-submitted by the MDS coordinator.</p> <p>2. All residents could potentially have been affected by this practice. An MDS review will be completed on all residents' dental status by the DON/designee to ensure accuracy of coding of the MDS. Residents' assessments that are identified with coding inaccuracies will have their MDS modified and corrected.</p> <p>3. It is determined that the MDS's for this resident was not coded appropriately. The MDS coordinator will be provided in-servicing on the importance of accurate MDS coding as it reflects the current status of the resident during the assessment period by the DON/designee. Policies and Procedures were reviewed and no revisions were necessary to achieve regulatory compliance.</p> <p>4. The DON/designee will conduct a random audit on three new admits weekly to assure compliance with the accuracy of MDS assessments and coding. Results threshold are established at 100%. Findings will be reviewed with the NHA with corrective action as needed and reviewed during the QA+A committee meetings. The QA+A committee may adjust the frequency of the monitoring as it is deemed appropriate.</p>	2/03/2015	
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F 278	Continued From page 9 quarterly MDS assessment. The facility failed to accurately reflect R21's dental status on the 10/19/15 quarterly MDS assessment.	F 278			
F 280 SS=D	Findings were reviewed with E1 and E2 during the exit conference on 12/10/15 at approximately 3:30 PM. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R30) out of 25 Stage 2 sampled residents, the facility failed to review and	F 280	1. R30 previously resided in the facility and was discharger on 8/24/2015. R30 is no longer a resident in the facility so no immediate action was taken. 2. All residents with urinary incontinence in their care plan could potentially have been affected by this practice. An audit will be conducted on all current residents incontinence care plans to ensure accuracy of the care plan. Residents who are identified as having inaccuracies on their care plans will be immediately corrected. 3. It is determined that the urinary incontinence care plan was not reviewed and revised for this resident. The care plan for this resident was not updated to reflect current care and services.		

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F 280	Continued From page 10 revise R30's urinary incontinence care plan. Findings include: Cross refer F315 The admission MDS assessment, dated 6/26/15, revealed that R30 was frequently incontinent of urine. R30 was care planned on 7/1/15 for urinary incontinence with approaches that included check for incontinent episodes at least every 2 hours; provide incontinence care after each incontinent episode and provide medications as ordered. The significant change MDS assessment, dated 7/20/15, revealed that R30 was always incontinent of urine. The 7/20/15 MDS assessment revealed an increase from frequently to always incontinent of urine for R30. R30's urinary incontinence care plan, dated 7/1/15, remained in place despite the increase from frequently to always on the 7/20/15 significant change MDS assessment. In an interview on 12/10/15 at 10:33 AM, findings were reviewed with E2 (DON). The facility failed to review and revise R30's urinary incontinence care plan when R30 increased from frequently to always incontinent of urine. Findings were reviewed with E1 (NHA) and E2 during the exit conference on 12/10/15 at approximately 3:30 PM.	F 280	3.(con't) Policies and Procedures were reviewed and no revisions were necessary to achieve regulatory compliance. All licensed staff will be in-serviced on care planning /updating the residents care plans according to policy by DON/designee. 4. A weekly audit of 5 random resident care plans will be reviewed by DON/designee for compliance of complete timely and accurate care plans. Result thresholds are established at 100% Audit findings will be reported to the NHA with immediate corrective action; and the outcomes will be reviewed at the QA+A committee meeting for compliance. The QA+A committee may adjust the frequency of the monitoring as it is deemed appropriate.	2/03/2015
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	END F280 F 309	1. R40 resides in the facility. An audit will be completed for R40's physician's order for blood pressure and anti-depressants medications. 2. Potentially, all residents who receive orders for anti-depressants or blood pressure medication could be affected by this practice.	

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F 309	<p>Continued From page 11 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and interview, it was determined that for two (R40 and R48) out of 25 Stage 2 sampled residents, the facility failed to ensure these residents received the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with physician's orders. For R40 the facility failed to follow physician's orders when an antidepressant was not given as ordered and a blood pressure medication was given when outside of ordered parameters. For R48, the facility failed to implement physician's orders when a psych consult was ordered and it did not occur until a surveyor brought it to the facility's attention. Findings include:</p> <p>1A. A physician's order, dated 11/20/15, ordered R40 to start Remeron (an antidepressant) daily at bedtime for depression.</p> <p>Review of the November 2015 MAR and NN's lacked evidence that on 11/27/15, R40 received the antidepressant as per physician's order.</p> <p>On 12/10/15 the findings were reviewed with E2 (DON) at approximately 3:30 PM.</p> <p>B. The December 2015 POS, stated that R40 was ordered Metoprolol (a blood pressure</p>	F 309	<p>2. (continued) An audit of residents who have orders for blood pressure medication , anti-depressants will be conducted to assure implementation and completion of these orders.</p> <p>3. It was determined that the facility failed to follow physicians orders for an anti-depressant for R40; and that blood pressure medication was given outside of ordered parameters for R40. An in-service will be given to all licensed staff by the DON/designee regarding physicians orders and the importance of implementation and completion of those orders.</p> <p>4. The DON/designee will complete a monthly audit on three random new admissions to ensure proper compliance. Result thresholds are established at 100%. Audit findings will be reported to the NHA with immediate corrective action as needed. Outcomes will be reviewed at the QA+A committee meeting for compliance. The QA+A committee may adjust the frequency of the monitoring as deemed appropriate.</p>		

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F 309	<p>Continued From page 12 medication) every other day and to hold the medicine if the following parameters were not met, SBP was <100 and heart rate <60.</p> <p>Review of the December MAR revealed that on 12/6/15, R48 was administered Metoprolol without evidence that her blood pressure and heart rate were taken prior to administration. Review of the NN's also lacked evidence of the SBP and the heart rate.</p> <p>For R40 the facility failed to follow the plan of ca with regards to specific doctor's orders for two medications.</p> <p>On 12/10/15 the findings were reviewed with E2 at approximately 3:30 PM.</p> <p>2. A physician note, dated 10/29/15, stated the reason for the visit was for R48's increased agitation and the plan was to start R48 on an antidepressant and a request was made for a psychiatric (psych) consult to evaluate the resident.</p> <p>A physician's order, dated 10/29/15, ordered R48 to start an antidepressant and to have a psych consult for increased agitation. Review of the clinical record on 12/9/15 lacked evidence that a psych consult was done.</p> <p>Findings were confirmed with E2 on 12/9/15 at 2:28 PM during an interview.</p> <p>A psychiatric note incorrectly dated 12/8/15, instead of 12/9/15, stated that staff reported that R48 had intermittent anxiety, calling out, attempting unsafe transfers, mostly on the evening shift, and was not easily redirected. The</p>	F 309	<ol style="list-style-type: none"> R48 resides in the facility. A psych consult was ordered for R48 when its omission was brought to attention by the surveyor. R48 was evaluated by Psych during survey. Potentially, all residents who receive Orders for anti-depressants and blood pressure medication could be affected by this practice. The DON/ designee will audit of residents who have orders for blood pressure medication and anti-depressants will be conducted to assure implementation and completion of these orders. It was also determined that orders for a psych consult for R48 were not followed. An in-service will be given by DON/Designee to all licensed staff regarding physicians orders and the importance of implementation and completion of those orders. The DON/designee will complete a monthly audit on three random new admissions to ensure proper compliance. Result thresholds are established at 100%. Audit findings will be reported to the NHA with immediate corrective action as needed. Outcomes will be reviewed at the QA+A committee meeting for compliance. The QA+A committee may adjust the frequency of the monitoring as deemed appropriate. 	2/03/2015
		END 309		

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F 309	Continued From page 13 plan was to continue to redirect inappropriate behaviors and document them and R48's medication was adjusted. For R48 the facility failed to obtain an ordered psych consult, until it was brought to the facility's attention by a surveyor (41 days after the order). Findings were reviewed with E1 (NHA) and E2 during the exit conference on 12/10/15 at approximately 3:30 PM. 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315	1.R30 was previously a resident in the facility and was discharged on 8/24/2015. Since the resident is no longer in the facility, no immediate action was taken. 2.All residents with urinary incontinence could potentially be affected by these practices. An audit will be completed by the DON/designee on all current residents who have urinary incontinence to assure correct and complete documentation. To ensure that future residents are receiving appropriate treatment and services to restore as much normal bladder function as possible.The comprehensive assessment for urinary incontinence and three day B&B sheets will be reviewed for completeness and that appropriate interventions are in place during the daily clinical meeting. 3. It was determined that the facility failed to provide the care and services to maintain and/or prevent a decline in bladder function as much as possible which resulted in an increase of R30's urinary incontinence from "frequently" to "always incontinent". This is evidenced by the failure to comprehensively assess the urinary incontinence; and failure to complete a bowel and bladder flow sheet upon admission. The facility also failed to monitor, implement, evaluate and/or revise care plan approaches that were ineffective.		
F 315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that one (R30) out of 25 Stage 2 sampled residents, who was incontinent of bladder, received appropriate treatment and services to restore as much normal bladder function as possible. For R30, the facility failed to comprehensively assess her urinary incontinence; failed to complete a 3-day B&B flow sheet; and failed to monitor, implement, evaluate and/or revise the care plan				

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F315	<p>Continued From page 14 approaches that were ineffective, resulting in a decline of her urinary continence. Findings include:</p> <p>The facility's policy entitled Bladder Elimination Assessment, last reviewed on 5/26/15, stated if a resident was incontinent, a detailed assessment would be completed using the Bladder Incontinence Evaluation form and a 3-Day B&B Flow Sheet. Upon completion, the information would be analyzed and a recommendation would be made if a retraining program was appropriate. If the resident refused to participate in the retraining program, the care plan would document the resident's refusal.</p> <p>R30 was admitted to the facility on 6/19/15 with a past medical history of urinary incontinence and UTI.</p> <p>The nursing Data Collection Tool, dated 6/19/15, revealed that R30 was alert and oriented, incontinent of bladder and she used pads/brlifs for urinary incontinence.</p> <p>Review of R30's clinical record revealed the absence of a 3-day B&B flow sheet.</p> <p>The Bladder Incontinence Assessment, dated 6/19/15, revealed that R30 was alert and oriented, required extensive assistance with toileting, had contributing factors/diagnoses including diabetes, use of diuretics (for removal of excess water in the body) and narcotics (for pain), the onset of incontinence was unable to be determined, there was diminished perception of the need to void and multiple daily episodes of bladder incontinence. It was unclear why the facility failed to identify additional significant</p>	F 315	<p>3. (continued) The DON/designee will conduct in – servicing with all nursing staff on the expectation related to the care and services provided to residents with urinary incontinence. The in-service will also encompass documentation, assessments and evaluations; and alternative approaches for residents with urinary incontinence who are non-compliant. Policies and procedures were reviewed and no revisions were necessary to achieve regulatory compliance.</p> <p>4. The DON/designee will complete a weekly audit on three random residents who have urinary incontinence. These audits will ensure that these residents are receiving appropriate treatment and services to restore as much normal bladder fundtion as possible. The audit will also ensure that the documentation is correct and complete. Results threshold are established at 100%. The results will be reviewed with the NHA, with corrective action as needed. Findings will be reviewed at the QA+A committee meeting. The QA+A committee may adjust the frequency of the monitoring as deemed appropriate.</p>	2/03/2015
		END F315		

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F 315	<p>Continued From page 15</p> <p>diagnoses including R30's previous history of urinary incontinence and the 6/10/15 UTI that was treated with an antibiotic. It was also unclear why the facility failed to identify that R30 was admitted on a medication, Oxybutynin, that was used to treat urinary incontinence.</p> <p>Further review of the 6/19/15 Bladder Incontinence Assessment revealed that the Summary section was blank, which lacked an analysis and recommendation on how to appropriately treat and provide services to restore as much normal bladder function as possible for R30. The facility failed to identify whether R30 was or was not recommended for a retraining program or chose not to participate in a program based on the comprehensive assessment. The facility failed to comprehensively assess R30 for urinary incontinence by failing to complete the bladder incontinence assessment and failing to complete the 3-day B&B flow sheet.</p> <p>R30 was care planned on 6/19/15 for alteration in urinary output with approaches that included check every 2 hours, provide good pericare as needed and pads/briefs/bedpan/bedside commode as needed.</p> <p>The admission history and physical, dated 6/23/15, stated that R30 had a UTI that resolved with antibiotic treatment; a past medical history of urinary incontinence; and that R30 was receiving Oxybutynin medication. Despite the above urinary history and R30's current medication for urinary incontinence twice a day, it was unclear why urinary incontinence, stated, "denied".</p> <p>The admission MDS assessment, dated 6/26/15, revealed that R30 was frequently incontinent of</p>				

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F 315	<p>Continued From page 16 urine and required extensive assist of 2 staff for toileting.</p> <p>Despite the lack of a comprehensive urinary assessment, R30 was care planned on 7/1/15 for urinary incontinence with approaches that included check for incontinent episodes at least every 2 hours; provide incontinence care after each incontinent episode and provide medications as ordered.</p> <p>R30 was discharged from the facility on 7/2/15 for an unrelated scheduled surgery and returned to the facility on 7/13/15.</p> <p>The nursing Data Collection Tool, dated 7/13/15, revealed that R30 was alert and oriented, incontinent of bladder and used pads/briefs for urinary incontinence.</p> <p>The 7/20/15 significant change MDS assessment revealed that R30 was always incontinent of urine; required extensive assist of 2 staff for toileting and rejection of care behavior occurred 4 to 6 days a week, but less than daily. The 7/20/15 MDS assessment revealed an increase from frequently to always incontinent of urine for R30.</p> <p>R30's urinary incontinence care plan, dated 7/1/15, remained in place despite the increase from frequently to always incontinent on the 7/20/15 significant change MDS. The facility failed to review and revise R30's incontinence care plan to address her increase in urinary incontinence.</p> <p>A 3-day B&B flow sheet was started on 7/21/15 and completed on 7/24/15. The 3-day B&B flow sheet evaluation stated, "Resident is A&O (alert &</p>	F 315			

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F 315	<p>Continued From page 17 oriented) ... able to make needs known. She states she prefers to relieve herself in briefs and allow staff to clean. Psy (psych) consult for depression".</p> <p>A nurse's note, dated 7/24/15 and untimed, stated, "3 day B&B assessment completed. (zero) patterns were established, resident stated she prefers to go in her underwear and have staff clean her up. Psych consulted for depression. She does not want to participate in a toileting program at this time".</p> <p>On 7/24/15, R30 was care planned for non-compliance with personal hygiene.</p> <p>On 8/5/15, R30 was evaluated by psych and found to have no evidence of depression.</p> <p>The Bladder Incontinence Assessment, dated 8/8/15, revealed that R30 was alert and oriented, onset of incontinence was 1+ years, perception of need to void was absent, there was no apparent voiding pattern, and there were daily incontinence episodes (some control). Associated symptoms included fills bladder/voids large amounts, relief after voiding was complete, environmental factors included distance to toilet/commode and high blood glucose within the last 60 days. Under the Summary section, R30 was recommended for a retraining program and the reason noted was incontinent.</p> <p>A nurse's note, dated 8/11/15 at 11:20 AM, stated that R30 "would rather be incontinent instead of going to toilet". R30 remained on a check and change toileting plan every 2 hours for urinary ncontinence.</p>	F 315			

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F 315	Continued From page 18 A physician's order, dated 8/20/15, stated that R30's Oxybutynin medication dose for urinary incontinence was adjusted. On 8/24/15, R30 was discharged from the facility. In an interview on 12/10/15 at 10:33 AM, findings were reviewed with E2 (DON). E2 stated that R30 was non-compliant with care. The facility failed to provide the care and services to maintain and/or prevent a decline in bladder function as much as possible which resulted in an increase in R30's urinary incontinence from frequently to always incontinent as evidenced by the: - failure to comprehensively assess her urinary incontinence upon the 6/19/15 admission; - failure to complete a 3-day B&B flow sheet upon the 6/19/15 admission; and - failure to monitor, implement, evaluate and/or revise care plan approaches that were ineffective. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure the	F 315			
F323 SS=D		F 323	<ol style="list-style-type: none"> The exposed rusty toilet bolts in room 138 and 139 were removed and replaced the same day (12/08/2015) the finding were reviewed with E13 (FMD). All residents could potentially be affected by this practice. An audit will be done on all residents' bathrooms to assure that all toilet bolts are in proper condition and that they are not defective by the maintenance Director/designee monthly for 3 months and then quarterly It was determined that during facility rooms rounds the toilet bolts were not reported. 		

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F 323	<p>Continued From page 19</p> <p>environment was free from accident hazards in two rooms (138 and 139) out of 30 rooms surveyed. Findings include:</p> <p>Observations made on 12/4/15 during Stage 1 review, and during the environmental tour on 12/8/15, between 2:00 PM and 2:30 PM, revealed the following:</p> <p>1. An exposed rusty toilet bolt was observed in the bathroom of room 138.</p> <p>2. An exposed rusty toilet bolt was observed in the bathroom of room 139.</p> <p>Findings were confirmed with E13 (FMD) on 12/8/15 during the environmental tour.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) on 12/10/15 at approximately 3:00 PM.</p> <p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition</p>	F 323	<p>3.(cont.)The NHA /designee will in-service the maintenance department to observe the toilet bolts during room rounds and repair as appropriate. Policies and procedures were reviewed and no revisions were necessary to achieve regulatory compliance.</p> <p>4.The Maintenance Director /designee will audit the resident rooms for defective toilet bolts monthly times 3 months then quarterly. Findings will be reviewed with the NHA with corrective action as needed. Audit findings will be reported to the Quarterly QAPI meeting. Results thresholds are established at 100%. The frequency of the audits will be adjusted according to outcomes.</p> <p>1.R91 resides in the facility. When the deficient practice was identified the DON/designee in-serviced the licensed staff specifically for R91 regarding proper medication administration as it relates to anti-anxiety medication emphasizing the use of behavior sheets and utilizing non-pharmaceutical interventions prior to administering medication and to document as appropriate.</p> <p>2. Residents that have been prescribed an anti-anxiety medication could potentially have been affected by this practice. An audit was done by the DON/designee of all residents on anti- anxiety medication to assure that each resident's drug regime is free from any unnecessary drugs as it relates to the proper use and documentation of the anti-anxiety behavior flow sheets and i non-pharmaceutical interventions prior to administration of medications. An audit will be completed going forward by the DON/designee to monitor licensed staff in their judgement of medication administration ensuring that there are indications for changes and/or administration of those medications. The DON/designee will hold a quarterly drug reduction review with psychologist on staff to free residents from unnecessary medications. DON/designee will follow up as appropriate.</p> <p>3.It was determined that the facility failed to implement non-pharmaceutical interventions prior to administering anti-anxiety medication and to consistently monitor its effects and on occasion failed to have an indication for usage of antianxiety medication.</p>	2/03/2015	
F 329 SS=D		END F 323 F 329			

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F 329	<p>Continued From page 20 as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that each resident's drug regimen was free from unnecessary drugs for two (R91 and R100) out of 25 Stage 2 sampled residents. For R91, the facility failed on multiple occasions to have an indication for the use of antianxiety medication; failed to implement non-pharmacological interventions prior to the use of antianxiety medication; and failed to consistently monitor its effectiveness. For R100, the facility increased the daily dosage of antipsychotic medication, despite a lack of evidence of a need or an indication for the increased dose. Findings include:</p> <p>1. R91 was admitted to the facility on 9/18/15. On 9/23/15, a physician's order was written for R91 to receive the antianxiety medication Ativan twice a day as needed.</p> <p>The 11/2015 and 12/2015 MARs revealed Ativan was administered as follows: - 11/1/15 4:40 PM - no indication for use noted on facility behavior monitoring sheet or in NN's; no evidence of non pharmacological interventions implemented prior to use; no evidence of</p>	F 329	<p>3. (con't) The licensed nursing staff will be in-serviced on medication administration related to anti-psychotic medications by the DON/designee. An audit will be done going forward to monitor licensed staff in their judgment of medication administration ensuring that there are indications for those changes. The DON/designee audited all residents' that are currently receiving anti-psychotics to identify discrepancies in monitoring the effects of anti-psychotic medication. The DON will hold a quarterly drug reduction review with psychologist on staff to free residents from unnecessary medications. DON/designee will follow up as appropriate. Policies and Procedures were reviewed and no revisions were necessary to achieve regulatory compliance.</p> <p>4. The DON/designee will perform weekly x4 weeks, and then monthly audits on 30% of the current population related to anti-psychotic medications. Behavior sheets as well as the nurse's notes will be monitored to verify effectiveness of the medications outcomes. The behavior sheets will be part of the Quarterly medication reduction review and outcomes be addressed as appropriate. Audit findings will be reported to the NHA. Results thresholds are established at 100% Findings will be reported at the QA+A committee meetings. The QA+A committee may adjust the frequency of the monitoring as deemed appropriate.</p>		
		F329	<p>1.R100 no longer resides in the facility and was discharged on 12/23/15. When the deficient practice was identified the DON/designee in-serviced the licensed staff specifically for R100 regarding proper medication administration as it relates to anti-psychotic medication emphasizing the use of behavior sheets and utilizing non-pharmaceutical interventions prior to administering medication and to document as appropriate.</p>	2/03/2015	

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F 329	<p>Continued From page 21</p> <p>monitoring for effectiveness; - 11/8/15 5:00 PM - no indication for use noted on facility behavior monitoring sheet or in NN's; no evidence of non pharmacological interventions implemented prior to use; no evidence of monitoring for effectiveness; - 11/9/15 2:15 AM - no indication for use noted on facility behavior monitoring sheet or in NN's; no evidence of non pharmacological interventions implemented prior to use; no evidence of monitoring for effectiveness; - 11/23/15 2:00 AM - no indication for use noted on facility behavior monitoring sheet or in NN's; no evidence non pharmacological interventions implemented prior to use; no evidence of monitoring for effectiveness; - 11/25/15 6:00 PM - MAR noted on back "increased anxiety" medication effective; no evidence of non pharmacological interventions implemented prior to use; - 11/28/15 7:00 PM - no indication for use noted on facility behavior monitoring sheet or in NN's; no evidence of non pharmacological interventions implemented prior to use; no evidence of monitoring for effectiveness; - 12/4/15 1:40 AM and 1:00 PM - no evidence of non pharmacological interventions implemented prior to medication use.</p> <p>The facility failed to consistently indicate the need for the use of Ativan, failed to attempt non pharmacological interventions prior to the use of the medication, and failed to consistently monitor it's effectiveness.</p> <p>On 12/10/2015 at approximately 1:02 PM, findings were reviewed with E2 (DON).</p> <p>2. R100 was admitted to the facility on 11/17/15</p>	F 329	<p>2. Residents that have been prescribed an anti-psychotic medication could potentially have been affected by this practice. An audit by the DON/designee was done of all residents on anti-psychotic medication to assure that each resident's drug regime is free from any unnecessary drugs as it relates to the proper use and documentation of the anti-psychotic behavior sheets and non-pharmacological interventions prior to administration of medications. Going forward an audit will be completed by the DON/designee to monitor licensed staff in their judgement of medication administration ensuring that there are indications for changes and/or administration of medications. The DON/designee will hold a quarterly drug reduction review with psychologist on staff to free residents from unnecessary medications. DON/designee will follow up as appropriate.</p> <p>3. It was determined the facility increased the daily dosage of anti-psychotic medication despite a lack of evidence of a need or an indication for the increased dosage. The licensed nursing staff will be in-serviced on medication administration related to anti-psychotic medications by the DON/designee. An audit will be done going forward to monitor licensed staff in their judgment of medication administration ensuring that there are indications for these changes. The DON/designee audited all residents that are currently receiving anti-psychotics to identify discrepancies in monitoring the effects of anti-psychotic medication. The DON will hold a quarterly drug reduction review with psychologist on staff to free residents from unnecessary medications. DON/designee will follow up as appropriate. Policies and Procedures were reviewed and no revisions were necessary to achieve regulatory compliance.</p>	

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F 329	<p>Continued From page 22</p> <p>post hospitalization. The admission orders, dated 11/17/15, included an order for the antipsychotic medication Seroquel 50 mg to be given once a day at bedtime.</p> <p>Review of hospital discharge records, dated 11/17/15, revealed R100 was taking Seroquel 50 mg once daily at bedtime prior to hospitalization.</p> <p>The facility developed an interim care plan on 11/17/15 for alteration in mood and behavior. Interventions included "Identify interventions that will help calm me."</p> <p>Review of the facility's Behavior/Intervention Monthly Flow Record revealed staff were monitoring R100 for behaviors of crying, agitation and/or anxiety. The Behavior/Intervention Monthly Flow Sheet lacked evidence that R100 had any behaviors from 11/17/15 through 11/24/15.</p> <p>Review of an incident report, dated 11/19/15 and timed 12:30 AM, revealed R100 was found lying on the fall mat next to the bed. An investigative statement, stated that R100 was not agitated prior to the fall.</p> <p>A psychiatry consult, dated 11/20/15, stated "...Initial Mental Status Evaluation, Medication management/assessment...cooperative...oriented to self...alert and calm and good eye contact. No significant care issues...Continue current psychiatric medication. Will continue to monitor..."</p> <p>Review of NN's from 11/17/15 through 11/24/15 revealed only one (1) NN's which documented an episode of anxiety. The NN, dated 11/22/15 and timed 7:45 AM, stated "Resident increase (sic) anxiety an (sic) she has increased risk for fall and</p>	F 329	4. The DON/designee will perform weekly x4 weeks, and then monthly audits on 30% of the current population related to anti-psychotic medications. Behavior sheets as well as the nurse's notes will be monitored to verify effectiveness of the medications outcomes. The behavior sheets will be part of the Quarterly medication reduction review and outcomes be addressed as appropriate. Audit findings will be reviewed with the NHA with corrective action as needed; and then reviewed during QAPI meetings. Results thresholds are established at 100% Findings will be reported at the QA+A committee meetings. The QA+A committee may adjust the frequency of the monitoring as deemed appropriate.		

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F 329	Continued From page 23 she was up most hour of the night (sic)." A physician's progress note, dated 11/24/15, stated, "staff reporting (increased) anxiety/agitation...Alert...NAD...(increased) anxiety/agitation - add Seroquel q AM..." On 11/24/15, a physician's order was written to increase R100's Seroquel to 50 mg every morning and 50 mg every evening. The 11/24/15 Seroquel order increased the daily dose to double what R100 had been receiving, despite there being only one (1) documented episode (NN dated 11/22/15 and timed 7:45 AM) where R100 experienced increased anxiety. There was no indication and/or justification in the clinical record warranting the increased dose of Seroquel for R100. During an interview on 12/10/15 at 9:15 AM with E2, findings were reviewed. E2 stated that R100 has been agitated since her arrival to the facility, especially during the evening and night shifts. E2 confirmed that documented evidence of these behaviors was lacking in the clinical record.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an Influenza immunization October 1 through March 31	F 334	1. R135 resides in the community. DON verified that the resident consent form was completed indicating the resident receive their annual immunization during their VA hospital stay prior to admission. This immunization form was completed at the VA hospital . This facility is unable to verify the exact date that the form was signed. The resident signed the consent form at the facility declining to have the immunization; as he had already received it at the VA. The facility consent form was completed and signed in the facility on 2/1/16. 2. All residents have the potential to be affected by this practice. An audit will be completed by the DON/designee on all residents as it relates to the completion of the immunization consent form and updated as appropriate. This audit has address all residents. All resident consent forms are complete.	

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NAME OF PROVIDER OR SUPPLIER FORWOOD MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1912 MARSH ROAD WILMINGTON, DE 19810		
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F 334	<p>Continued From page 24</p> <p>annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of</p>	F 334	<p>3 It was determined that the facility did not verify that R135 received annual immunization for influenza and pneumonia. The licensed staff will be in serviced by the DON/designee on procedures for completion of annual immunization forms for influenza and pneumonia and the need to educate resident/family members on the benefits and/or potential side effects of influenza and pneumococcal immunizations. An acceptance or refusal of the immunizations should be documented. Policies and procedures were reviewed and no revisions were necessary to achieve regulatory compliance.</p> <p>4. The DON/designee will complete a weekly audit on new admissions as it relates to the completion and verification of the consent form for immunization for influenza and pneumonia weekly x4 and then monthly for one quarter. Any discrepancies will be addressed appropriately upon discovery and corrected immediately. Findings will be reported to the NHA. Findings will also be reported at the QA+A committee meetings. The QA+A committee may adjust the frequency of the monitoring as deemed appropriate.</p>	2/03/2015	
		END F334			

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F 334	<p>Continued From page 25</p> <p>pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that a resident's medical record included documentation that indicated, at a minimum, that the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza and pneumococcal immunizations and that the resident either received or refused the immunizations with a stated reason for one (R135) out of five Census sampled residents. Findings include:</p> <p>The facility's policy entitled, "Resident Health Program, Resident Immunization Consent Form...", dated 8/6/03, stated, "I have received the Pneumococcal... handout... I have received the current... Influenza... handout... All my questions have been answered. I understand the benefit and risks of the vaccines and request that the: (Indicate your wishes by checking the appropriate space) Pneumococcal vaccine to be</p>	F 334			

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F 334	<p>Continued From page 26</p> <p>administered ____; Pneumococcal vaccine not to be given ____; If not to be given, please state reason: ____; Influenza vaccine to be administered annually ____; Influenza vaccine not to be given annually ____; If not to be given, please state reason: ____... Signature of Resident, Date... Signature/Telephone Consent: of Responsible Party, Date...".</p> <p>R135's POS, dated 11/30/15, included vaccination orders to administer the flu vaccine annually, unless allergic and to administer the pneumococcal vaccine once upon admission if not given in the last five years, unless allergic.</p> <p>The Admission MDS, dated 12/4/15, stated R135 was moderately cognitively impaired.</p> <p>Review of R135's clinical record revealed there was no immunization consent form completed for the resident.</p> <p>On 12/10/15 at 9 AM, in an interview with E3 (ADON) and the surveyor, R135 stated that he went to the Veteran's Administration annually and they had given him shots there. R135 stated he thought it was in September, but did not know the date nor did he specify what shots he received.</p> <p>On 12/10/15 at 9:40 AM, in an interview, E3 confirmed the findings that there was no immunization consent form completed for R135.</p>	F 334		
F 463 SS=D	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing</p>	F 463	<p>1. The call bell box in room 105 bed B was remounted / repaired (12/04/2015) the same day the finding were reviewed by E13. Both call bells in room 122 were working properly, however a resident was not able to activate.</p>	

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F 463	<p>Continued From page 27 facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure that the call bell system was functioning for four (105, 122, 124, and 148) out of 30 rooms reviewed. Findings include:</p> <ol style="list-style-type: none"> On 12/4/15 at 12:05 PM, the call bell for room 105B was not functioning properly. The call bell box was observed to be partially disconnected from the wall. E15 (CNA) confirmed the finding and notified maintenance. On 12/4/15 at 11:35 AM, the call bells for both 122A and 122B were not functioning properly. R15 pressed her call bell multiple times and it did not activate. On 12/4/15 at 11:36 AM, E14 (CNA) confirmed the findings and notified maintenance. On 12/4/15 at 11:39 AM, room 124's call bell activated the light above the door outside the room, however, there was no audio heard. On 12/8/15 at approximately 2:00 PM, E2 (DON) confirmed the finding and subsequently turned the alarm volume up at the nursing station. On 12/4/15 at 3:06 PM, room 148's call light cord was wrapped around the hand rail in the bathroom. This prevented the call light from being activated when pulled. <p>Findings were reviewed and confirmed with E13 (FMD) on 12/8/15 during the environmental tour at approximately 2 PM.</p>	F 463	<ol style="list-style-type: none"> (Cont.) The resident R15 was educated that day on activating the call with a positive result. The call bell audio for room 124 was adjusted at the nurses' station by the DON on the day of the findings (12/08/2015). The call bell cord room 148 in the bathroom was not properly placed. E13 re- positioned the call bell and reported it to the DON on the day of the findings (12/04/2015). All residents could potentially be effected by these practices. All rooms have been audited to ensure that call bell cords are properly placed and that the nurse's station audio is at the proper setting. An audit will be done weekly x3 to ensure the audio stays at the proper volume in the nurse's station. It was determined that the call bells have not been reported to be defective by staff, the volume had been turned down at the nurses' station, education needed to be provide to residents related to the use of the call bell, and the placement of the call bell was not correct. The nursing staff will be in-serviced by the NHA / designee to report observed defective call bells to the maintenance department immediately. All licensed staff will be in-service by the DON / designee to ensure that the volume for the call bell system is audible. 		

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F 514	<p>Continued From page 30 the November 2015 MAR and TAR were missing.</p> <p>On 12/10/15 at 8:45 AM, E2 (DON) stated that staff stayed late in the facility the day before and she had the filing person come in early that morning to find the missing records. E2 confirmed, however, that R48's November MAR and TAR were still missing.</p> <p>B. Review of R48's Data Collection Tool, dated 12/6/15, inaccurately stated that R48 had no allergies and was not receiving an antidepressant. Review of the December 2015 POS stated that R48 had allergies to ten different medications and she was ordered a daily antidepressant to be administered twice a day.</p> <p>Review of the December 2015 MAR revealed that R48 did receive her antidepressant medication from 12/1/15 through to 12/6/15, which was not captured on the Data Collection Tool, dated 12/6/15.</p> <p>In an interview, on 12/10/15 at 11:18 AM, E2 confirmed the findings.</p> <p>Findings were reviewed with E1 (NHA) and E2 during the exit conference on 12/10/15 at approximately 3:30 PM.</p> <p>2. R30 was admitted to the facility on 6/19/15 and was care planned for urinary incontinence with an approach that included to check and change her every 2 hours.</p> <p>Review of R30's Bowel and Bladder Detailed Entry Report from 6/22/15 through 7/2/15 revealed a lack of documented evidence of toileting every 2 hours. R30's urinary incontinence</p>	F514	<p>3(cont) accurate, and readily accessible. In-servicing will be conducted by the DON/designee for all nursing staff members who enter and document information on the clinical charts. The DON/ designee will in-service the medical records clerk to follow the closed records policy/ procedure to maintain the records. Policies and procedures were reviewed and no revisions were necessary to achieve regulatory compliance.</p> <p>4. A weekly audit of f 3 clinical records will be done on three random closed records; and weekly audits will be done on the completed closed records for that week.. Result thresholds are established at 100%. Audit findings will be reported to the NHA with immediate corrective action as needed; and the outcomes will be reviewed at the QA+A committee meetings for compliance. The QA+A committee may adjust the frequency of the monitoring as deemed appropriate</p> <p>1B) .R48 still resides in the community. The facility failed to reflect the use of an antidepressant and medication allergies for this resident. The clinical records for the resident (The Data Collection Tool); has been revised and posted in the residents chart on 12/10/15 to reflect medication allergies and the anti-depressant medication.</p> <p>2B. All residents that receive antidepressant or or have allergies to medication could potentially be affected by this practice. . During the daily clinical meeting all new residents with medication allergies and anti-depressant medication will have a medication review related to their medication orders for possible negative outcomes and any discrepancies will be addressed to the attending Physician.</p> <p>3B. It has been determined that the facility had failed to reflect the residents current condition related to medication allergies and antidepressant medications on the Data Collection Tool. In-servicing will be conducted by the DON/designee for all nursing staff members who enter and document information on the Data Collection Tool to ensure this tool reflects correctly what is reported on the POS. Policies and procedures were reviewed and no revisions were necessary to achieve regulatory compliance.</p> <p>4B.A weekly audit of of 3 Data Collection Tools will be done on 50% of all new residents . The Data Collection Tool will be reviewed to ensure accurate information as compared to the POS. Result thresholds are established at 100%. Audit findings will be reported to the NHA with immediate corrective action; and the outcomes will be reviewed at the QA+A committee meetings for compliance. The QA+A committee may adjust the frequency of the monitoring as deemed appropriate.</p>	2/3/15

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F 514	<p>Continued From page 31</p> <p>episodes were only documented once a shift, specifically at the end of each shift. It was unclear why the facility was not documenting toileting each time care was provided.</p> <p>R30 was discharged from the facility on 7/2/15 and readmitted on 7/13/15.</p> <p>On 7/13/15, R30 remained on the same check and change every 2 hours toileting care plan.</p> <p>Review of R30's Bowel and Bladder Detailed Entry Report from 7/13/15 through 8/24/15 revealed inconsistent documented evidence of toileting every 2 hours on each shift.</p> <p>In an interview on 12/10/15 at 10:33 AM, findings were reviewed with E2. The facility failed to maintain clinical records for R30 in accordance with accepted professional standards and practices that are complete and accurately documented for R30's toileting care needs.</p>	F514	<p>1.R30 was previously a resident in the facility and was discharged on 8/24/15. The facility failed to document toileting every two hours on a consistent basis as care planned. The DON/designee will in-service the staff to document according to the care plans.</p> <p>2. All residents care planned for urinary incontinence have potential to be affected by this practice. The DON/designee will in-service all nursing staff to follow the care plans and to document on a consistent bases. The DON/designee will review the Care Tracker tool each shift for completeness of documentation as it relates to toileting.</p> <p>3.It has been determined that the facility failed to document toileting on the B&B detailed entry report every two hour on consistent bases as care planned for R30. In-servicing will be conducted by the DON/designee for all nursing staff members who enter and document information related to B&B documentation. Policies and procedures were reviewed and no revisions were necessary to achieve regulatory compliance.</p> <p>4. A weekly audit by the DON/ designee will be completed of 50% of new admissions to compare the documentation to ensure that the documentation on the detailed B&B reports reflects what is care planned. Result thresholds are established at 100%. Audit findings will be reported to the NHA with immediate corrective action; and the outcomes will be reviewed at the QA+A committee meetings for compliance. The QA+A committee may adjust the frequency of the monitoring as deemed appropriate.</p>	2/03/2015
		END F514		



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Forwood Manor

DATE SURVEY COMPLETED: December 10, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual survey was conducted at this facility from December 4, 2015 through December 10, 2015. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 53. The Stage 2 survey sample size was 25.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>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.</p> <p>This requirement is not met as evidenced by: Cross refer to the CMS 2567-L Annual Survey ending December 10, 2015- F253, F272, F278, F280, F309, F315, F323, F329, F334, F463, F504, and F514.</p>	<p>Cross refer to the CMS 2567 –L Annual Survey ending December 10, 2015, <u>Plans of Correction for:</u></p> <p><u>F253, F272, F278, F280, F309, F315, F323, F329, F334, F463, F504, and F514</u></p>	

Provider's Signature  Title L NHA Date 2/8/16