STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085036	A. BUILDING _____ B. WING _____	10/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORWOOD MANOR	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	INITIAL COMMENTS An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from October 15, 2019 through October 22, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census the first day of the survey was 39. The survey sample size was 24 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; Contracture - a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints; Documentation Survey Report - a report in which CNAs document the care provided to a resident on each shift; DON - Director of Nursing; Functional Limitation in Range of Motion - limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living) or places the resident at risk of injury; Gerichair - wheelchair type- chair that reclines; Hand Hygiene - performing hand washing, antiseptic hand wash, alcohol based hand rub, surgical hand hygiene/antisepsis; Hand Washing - washing hands with plain soap or a cleaning agent and water; Kling roll - a gauze roll that is highly-absorbent, conforms to the bodies contours and moves with the bodies motions; LPN - Licensed Practical Nurse; MD - Medical Doctor;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/18/2019

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 MDS - Minimum Data Set/standardized assessment tool used in long term care facilities; Nebulizer - an electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece; Nebulizer Treatment- changes liquid medication into fine mist to breathe directly into lungs; NHA - Nursing Home Administrator; OT - Occupational Therapy/Therapist; PT - Physical Therapy; PTA - Physical Therapy Assistant; RD - Registered Dietitian; RN - Registered Nurse; ROM - Range of Motion; Systolic Blood Pressure (SBP) - the top number of the blood pressure reflects pressure in vessels when the heart is beating; TAR - Treatment Administration Record.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		12/22/19

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F 550	Continued From page 2 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that one (R22) out of 24 sampled residents was treated with respect and dignity. Findings include: Review of R22's clinical record revealed the following: R22's care plan stated that starting on 8/19/19, R22 required an indwelling urinary catheter (small tube used to drain urine from the bladder) related to urinary retention. Observations on 10/15/19 at 2:38 PM, 10/16/19	F 550	1. R22 had his urinary bag placed into a privacy bag by DON/designee. 2. All residents who have a urine collection bag are at risk for this practice. All residents with urine collection bags have been audited to ensure placement of a privacy bag. 3. A root cause analysis was completed and identified a knowledge deficit. The results will be discussed at the monthly QAPI meeting. All residents with urine drainage bags will have a privacy bag in place at all times. Nursing staff will be in-serviced on the use of privacy bag for	

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F 550	Continued From page 3 at 10:00 AM, multiple times throughout the day on 10/17/19 and on 10/18/19 at 9:07 AM revealed R22 lying in bed with a urinary drainage bag visible from the hallway. The collection bag was approximately half filled with amber urine, was not covered and was visible to anyone passing by in the hallway. 10/21/19 at 12:38 PM - During an interview, E4 (ADON) confirmed that the facility uses privacy bags to cover urinary collection bags for privacy and dignity. The facility failed to ensure that R22 was treated with respect and dignity when his catheter drainage bag was left uncovered and visible to anyone in the hallway or entering his room. 10/22/19 at 3:20 PM - Findings were reviewed with E2 (DON) and E4.	F 550	residents who have urine drainage bags by DON/designee. 4. A privacy bag audit will be completed weekly x 2 weeks until 100%, then monthly x 2 months until 100% by DON/designee. Results from the audits will be presented to the monthly QAPI Committee for review and recommendations as necessary.	
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on employee training reviews, review of	F 607	E4, E15, E16, E17 and E18 have	12/22/19

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F 607	Continued From page 4 the facility policy and procedure, and interview, it was determined that the facility failed to implement it's policy on abuse prohibition and prevention regarding the training of employees on abuse. Five (E4, E15, E16, E17, and E18) out of 10 sampled employees did not have annual abuse training. Findings include: The facility policy titled, Abuse Prohibition and Prevention Program, with a revision date of 10/10/18, stated, "...Abuse Prohibition and Prevention Program training will be provided to all employees during orientation and at a minimum, on an annual basis..." The following employees failed to have annual abuse training: E4 (ADON) - last training 10/7/14; E15 (LPN) - last training 5/16/18; E16 (CNA) - last training 4/25/18; E17 (RD) - last training 4/9/18; E18 (RN).- last training 7/6/18. The facility failed to ensure that 5 (E4, E15, E16, E17, and E18) out of 10 employees sampled failed to have annual abuse and prevention training. 10/22/19 at 5:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (Corporate Nurse, and E4 (ADON).	F 607	completed abuse and prevention training by ED/designee. 2. All residents have the potential to be affected by this practice. All employee files have been audited by ED/designee to ensure they have completed abuse and prevention training. Any employee non-compliant with this standard will have the training completed by 12/22/19 by ED/designee. 3. A root cause analysis was performed and results identified process issue in maintaining continuity of responsibilities with staff transition. The root cause will be discussed at the monthly QAPI meeting. All employees will have abuse and prevention training on hire and annually thereafter. Human Resources and department heads will be in-serviced by ED/designee on tracking and scheduling employees□ abuse and prevention training on their yearly anniversary. In the absence of HR the department managers will be responsible for ensuring this education is completed. 4. On their anniversary date employee files will audited by ED/designee monthly to make sure annual education is completed x 2 months until 100%. Results of the audits will be reported to the monthly QAPI Committee for review and recommendations.	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized	F 636		12/22/19

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F 636	Continued From page 5 reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.	F 636		

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F 636	Continued From page 6 §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for two (R2 and R17) out of three residents sampled for activities, the facility failed to ensure that comprehensive annual MDS assessments were conducted to include the activity portion (interviews with family or significant other and/or activity preferences). Findings include: 1. Review of R2's clinical record revealed: 8/29/14 - R2 was admitted to the facility with diagnoses that included dementia and difficulty walking. 10/16/19 at 11:04 AM - R2 was observed sleeping in a geri-chair (type of recliner) in the activity room. 10/17/19 at 10:09 AM - R2 was observed sleeping in bed.	F 636	1. An activity evaluation was completed for both residents by the activity director. 2. All residents have the potential to be affected by this practice. The activity director/designee will audit all residents medical record to ensure that a yearly activity evaluation has been completed, those identified needing an evaluation will have one completed by activity director/designee. 3. A root cause analysis was conducted and revealed a knowledge deficit regarding the process of Assessment. The results will be presented in the monthly QAPI meeting. All residents will have an activity evaluation on admission, annually and with significant change. The activity staff will be in-serviced by the Executive Director/designee on the scheduling of activity evaluation annually and with significant change.	

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F 636	Continued From page 7 10/17/19 at 2:36 PM - R2 was observed sleeping in bed with the lights off. 10/18/19 at 10:30 AM - R2 was observed sleeping in a geri-chair in the activity room. 10/18/19 at 1:10 PM - During an interview, E5 (Activity Director) confirmed that R2 did not have an annual MDS activity assessment. 2. Review of R17's clinical record revealed: 3/14/18 - R17 was admitted to the facility with diagnoses that included dementia and slurred speech following a stroke. 3/19/18 - An admission activity assessment was completed for R17. 10/16/19 at 10:46 AM - R17 was observed in her room throughout the morning. 10/16/19 at 1:48 PM - R17 was observed sitting in front of the nurses station with her eyes closed. 10/17/19 at 10:16 AM - R17 was observed in the activity room for trivia, awake and observing the activity. 10/18/19 at 1:10 PM - During an interview, E5 (Activity Director) confirmed that R17 did not have an annual MDS activity assessment. The facility failed to conduct R2 and R17's annual MDS comprehensive assessments, including interviews and/or activity preferences. Findings were reviewed with E2 (DON) and E4	F 636	4. A random monthly audit of 10% of the residents will be conducted by ED/designee to ensure that the yearly/significant change activity evaluation has been completed in the appropriate time frame x 2 months until 100%. Results of the audits will be reported to Monthly QAPI Committee for review and recommendations.	

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F 636	Continued From page 8 (DON) on 10/22/19 at 3:20 PM.	F 636		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		12/22/19

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F 656	Continued From page 9 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined that the facility failed to develop and implement comprehensive activity care plans for three (R2, R9, and R17) out of three residents sampled for activities. Findings include: 1. Review of R2's clinical record revealed: Cross refer F636, example #1 8/29/14 - R2 was admitted to the facility with diagnoses that included dementia and difficulty walking. 4/12/19 - The annual MDS assessment revealed that R2 was severely cognitively impaired and was rarely understood and that R2 was totally dependent on two persons for transfer to the wheelchair. 7/15/19 - The care plan for R2 was revised. Review of this document revealed no person centered activity care plan describing R2's activity preferences, measurable objectives, or timeframe's. 10/16/19 at 11:04 AM - R2 was observed sleeping in a geri-chair (type of recliner) in the activity room. 10/17/19 at 10:09 AM - R2 was observed	F 656	1. Activity care plans have completed for R2, R9 & R17 by the activity director. 2. All residents have the potential to be affected by this practice. Care plans for all residents will be reviewed by the activity director to ensure that a comprehensive activity care plan is in place. 3. A root cause analysis was conducted and revealed a knowledge deficit regarding the process individualized care planning and documentation. The results will be presented in the monthly QAPI meeting. A comprehensive activity care plan will be developed on admission, review/revised quarterly, annually and with significant change. The activity staff will be in-serviced by the Executive Director/designee on the requirement to develop and implement comprehensive activity care plans. 4. A random weekly audit of 10% of residents□ activity care plan and documentation will be conducted by ED/designee to make sure a comprehensive activity care plan has been developed and implemented for 2 weeks until 100%, then monthly x 2 monthly until 100% compliant. Results of the audits will be reported to the monthly QAPI Meeting for review and	

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F 656	Continued From page 10 sleeping in bed. 10/18/19 at 10:30 AM - R2 was observed sleeping in a geri-chair in the activity room. 10/18/19 at 1:10 PM - During an interview, E5 (Activity Director) confirmed that there was no activity care plan for R2. 2. Review of R9's clinical record revealed: Cross refer F679 3/8/17 - R9 was admitted to the facility with diagnoses that included right sided paralysis and difficulty speaking following a stroke. 8/6/19 - The quarterly MDS assessment revealed that R9 was severely cognitively impaired and was rarely understood, that R9 did not transfer from her bed to the wheelchair, and that R9 did not move between locations in her room and other areas of the facility. 8/8/19 - R9's care plan was revised. Review of the care plan revealed there was no person centered activity care plan describing R9's activity preferences, measurable objectives, or timeframe's. 10/16/19 - R9 was not observed in any activities throughout the day. 10/17/19 at 1:11 PM - R9 was observed lying in bed with the television on and her eyes closed. 10/17/19 at 9:40 AM - R9 was observed sitting up in bed with the television on and her eyes closed. 10/18/19 at 1:10 PM - During an interview, E5	F 656	recommendations	

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F 656	Continued From page 11 (Activity Director) confirmed that there was no activity care plan for R9. 3. Review of R17's clinical record revealed: Cross refer F636, example #2 3/14/18 - R17 was admitted to the facility with diagnoses that included dementia and slurred speech following a stroke. 9/12/19 - The quarterly MDS assessment revealed that R17 was severely cognitively impaired and was rarely understood, and that R17 was totally dependent on two persons for transfer to the wheelchair. 9/13/19 - R17's care plan was revised. Review of the care plan revealed there was no person centered activity plan describing R17's activity preferences, measurable objectives, or timeframe's. 10/16/19 at 10:46 AM - R17 was observed in her room throughout the morning. 10/16/19 at 1:48 PM - R17 was observed sitting in front of the nurses station with her eyes closed. 10/17/19 at 10:16 AM - R17 was observed in the activity room for trivia, awake and observing the activity. 10/18/19 at 1:10 PM - During an interview, E5 (Activity Director) confirmed that there was no activity care plan for R17. The facility failed to develop a comprehensive and individualized activity care plan for R2, R9, and R17.	F 656		

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F 656	Continued From page 12 Findings were reviewed with E2 (DON) and E4 (ADON) on 10/22/19 at 3:30 PM.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to review and revise the comprehensive care plan for one	F 657	1. Resident R9□s care plan was revised to reflect the discontinuation of the splint by DON/designee.	12/22/19

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F 657	Continued From page 13 (R9) out of 22 sampled residents. Findings include: Cross refer, F688 Review of the clinical record revealed the following: R9 was admitted to the facility on 3/8/17 with diagnoses that included stroke with paralysis of one side of the body. 3/21/18 - A physician's order stated, "Patient to wear right hand comfy splint (used to ensure proper positioning during sleep). On at 2200 (10 PM) off at 0600 (6 AM) with skin checks." 4/1/19 - Review of the TAR revealed that R9's right hand comfy splint was discontinued. A care plan, last reviewed on 8/8/19, stated R9 "is non-compliant with right hand splint, removes it frequently." The care plan stated to continue with the plan of care and that the resident continues to be non-compliant. The goal of the care plan was the resident will wear the splint as recommended. A care plan, last reviewed on 8/8/19, stated R9 had "impaired physical mobility related to right arm: refuses arm/hand splint." The care plan stated to continue with the plan of care. Interventions included to apply a right hand comfy splint at 10:00 PM and remove at 6:00 AM. A care plan, reviewed on 5/7/19, stated R9 had "impaired physical mobility related to decreased joint function: right finger/hand...". The care plan review stated there was no change, R9 refused the splint, and a rolled up washcloth in the right hand. The care plan was again reviewed on	F 657	2. All residents who are in need of splinting have the potential to be affected by this practice. A review of the care plan for residents who have an order for splinting to ensure that care plan goals and interventions are revised in accordance with the residents need/progress. 3. A root cause analysis was conducted and showed knowledge deficit and process delay in updating care plan and completing documentation of interventions. The results will be presented to the monthly QAPI meeting. Residents in need of splinting will have their care plans reviewed with changes, quarterly, annually and with significant changes. The licensed nursing staff will be in-serviced on revising care plans according to the residents need/status by the DON/designee. 4. A weekly audit of residents with splints care plans to ensure the residents needs and or progression are documented for 2 weeks until 100%, then monthly x 2 months until 100% compliant. Results of the audits will be reported to the monthly QAPI Committee for review and recommendations.	

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F 657	Continued From page 14 8/8/19 and stated there was no change and to continue the plan of care. A care plan, last revised on 8/8/19, stated R9 was at increased risk for actual/potential limitation in ability to perform activities of daily living. Interventions included, "resident requires splint to right hand on at 10 PM off at 6 AM non-compliant." A care plan, last revised on 10/19/19, stated R9 had the potential for impairment to skin integrity. Interventions included to apply a right hand splint per MD order and for PT to evaluate the hand splint. The facility failed to revise R9's care plans to reflect the resident's current status regarding the right hand comfy splint. Although the splint was discontinued on 4/1/19, care plans continued to state it was to be applied and that R9 was non-compliant with application of the splint. 10/21/19 approximately 3:00 PM - Findings were reviewed with E2 (DON). 10/22/19 approximately 5:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2, E3 (Corporate Nurse), and E4 (ADON).	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of	F 679		12/22/19

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F 679	Continued From page 15 activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review, it was determined that the facility failed to provide ongoing activities for one (R9) out of three residents sampled for activities. Findings include: Review of R9's clinical record revealed: 3/8/17 - R9 was admitted to the facility with diagnoses that included right sided paralysis and difficulty speaking following a stroke. 2/6/19 - The annual MDS assessment revealed that R9's preferences included, keeping up with the news, participating in favorite activities (no list of favorite activities), and choosing what clothes to wear. 8/6/19 - The quarterly MDS assessment revealed that R9 was severely cognitively impaired and was rarely understood, that R9 did not transfer from her bed to the wheelchair, and that R9 did not move between locations in her room and other areas of the facility. 8/8/19 - The care plan for R9 was revised. Review of the care plan revealed there was no person centered activity plan describing R9's activity preferences, measurable objectives, or timeframe's.	F 679	1. Activity director reviewed the resident□s preferences and developed a resident centered activity program and revised the resident□s care plan to reflect the developed program by DON/designee. 2. All residents have the potential to be affected by this practice. All residents□ care plans will be reviewed and compared with the activity evaluation and a resident centered activity program will be developed and care planned as needed by the activity director. 3. A root cause analysis was conducted and revealed a knowledge deficit regarding the process of Assessment through individualized care planning and documentation. The results will be presented in the monthly QAPI meeting. All residents will have an activity evaluation on admission, annually and significant change and a resident centered activity program developed and revised as needed. Activity staff will be in-serviced by the ED/designee on identifying residents□ preferences and developing a resident centered program. 4. An audit will be conducted by the Activity director/ designee prior to each residents care plan meeting to ensure that an assessment is completed, individual care plan has been developed based on	

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F 679	Continued From page 16 10/15/19 at 2:47 PM - R9 was observed lying in bed in a hospital gown with the television on and her eyes closed. 10/17/19 at 1:11 PM - R9 was observed lying in bed in a hospital gown with the television on and her eyes closed. 10/17/19 at 9:40 AM - R9 was observed sitting up in bed in a hospital gown with the television on and her eyes closed. 10/18/19 at 10:30 AM - During an interview, E11 (Activity Assistant) stated she 'pops in' to each resident's room and says hello on a daily basis. Review of the August 2019, September 2019 and October 2019 Resident Daily Attendance Records for R9 revealed that out 80 opportunities for R9 to participate in activities, the only activities documented were 28 pop in visits and 4 family visits. The facility failed to implement a resident centered activity program for R9 that incorporated her interests, in order to maintain or improve her mental and psychosocial well-being. Findings were discussed with E2 (DON) and E4 ADON) on 10/22/19 at 3:20 PM.	F 679	assessed needs and interests and documentation of interventions is in place. The audit schedule will ensure that each resident is reviewed at minimum of quarterly or upon significant change in condition to identify any need for revision and develop a resident center program according to the revision. Results of the audit will be presented to the monthly QAPI meeting for review and recommendations.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		12/22/19

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F 684	Continued From page 17 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined that for one (R7) out of 5 sampled residents for unnecessary medication review, the facility failed to provide treatment and care based on the comprehensive care plan, the consultant pharmacist's recommendation, and professional standards of practice when the facility failed to follow the physician ordered parameters for R7's high blood pressure medication. Findings include: Review of R7's clinical record revealed: 4/10/17 - R7 was admitted to the facility with diagnoses that included high blood pressure and heart failure. 10/12/17 - A physician's order was written for Carvedilol (blood pressure medication) two times a day for high blood pressure. Special instructions included to hold the medication for a systolic blood pressure of less than 120 or a heart rate of less than 60. 7/25/18 - A care plan was initiated for a potential for decreased cardiac output related to high blood pressure. Interventions included to administer medication per physician order. 1/22/19 - The consultant pharmacist report included the comment, "REPEATED RECOMMENDATION from 11/27/18: R7 has an order for Carvedilol... that was administered	F 684	1. A review of the discrepancies and the identified nurse administering the medication will be in-serviced and a competency performed on medication with parameters by DON/designee. 2. All resident receiving medications with parameters have the potential to be affected by this practice. A 90 day review of medication administration records of residents receiving medications with parameters will be conducted by the DON/designee to identify any administration of medication outside the defined parameters. Any nurse who was identified giving the medication erroneously will be in-serviced and a competency performed on medication with parameters by the DON/designee. 3. A root cause analysis was performed and identified documentation process and staff performance issue. The results will be presented to the monthly QAPI meeting. All residents receiving medication with parameters will be reviewed twice by the nurse administering the medication to ensure that the resident is within the parameters stated. All licensed nurses will be in-serviced by the DON/Designee on administering and documenting medications with parameters 4. All residents with medications that	

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F 684	Continued From page 18 despite a heart rate of 56." The pharmacist recommendation was to remind nursing staff of the importance of administering/holding medication within the parameters ordered. This form was signed by E2 (DON) on 1/24/19. Review of the May 2019 MAR revealed six occasions when R7's medication was given outside of the ordered parameters. Review of the June 2019 MAR revealed two occasions when R7's medication was given outside of the ordered parameters. Review of the July 2019 MAR revealed three occasions when R7's medication was given outside of the ordered parameters. Review of the August 2019 MAR revealed two occasions when R7's medication was given outside of the ordered parameters. Review of the September 2019 MAR revealed two occasions when R7's medication was given outside of the ordered parameters. Review of the October 2019 MAR revealed two occasions from 10/1/19 through 10/18/19 when R7's medication was given outside of the ordered parameters. The facility failed to follow the physician's order to hold R7's blood pressure medication for a systolic blood pressure of less than 120 or a heart rate of less than 60 on 17 occasions in the previous six months. Findings were reviewed with E2 (DON) and E4 (ADON) on 10/22/19 at 3:20 PM.	F 684	have parameters will be reviewed weekly for appropriate administration x 2 weeks until 100%, then monthly x 2 months until 100%. Results of the audits will be present at the monthly QAPI meeting for review and recommendations.	

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F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined that the facility failed to ensure that a resident with limited range of motion (ROM) receives appropriate treatment and services to increase range of motion and/or to prevent a further decrease in range of motion for one (R9) out of two (2) residents investigated. Findings include: Cross refer, F657 Review of R9's clinical record revealed the following: R9 was admitted to the facility on 3/8/17 with diagnoses that included stroke with paralysis of one side of the body.	F 688	1. A referral was made to therapy to assess the residents hand and make recommendations to prevent decreases in current range of motion by DON/designee. 2. All residents with limited range of motion have the potential to be affected by this practice. All residents with limited range of motion will be reviewed by the DON designee to ensure that they are receiving an appropriate range of motion program and that program has a care plan developed identifying the residents needs and completed documentation of the interventions. 3. A root cause analysis showed knowledge deficit and process delay in	12/22/19

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F 688	Continued From page 20 3/15/17 - An admission MDS assessment stated R9's cognitive skills for daily decision making were severely impaired (never/rarely made decisions), and R9 had a functional limitation in ROM of both the upper and lower extremity on one side. 6/21/17 - The facility's ROM Assessment stated that the finger extension of R9's right hand was limited (inability to open hand fully). 2/22/18 - The facility's ROM Assessment stated that the finger extension of R9's right hand was severely limited. 3/21/18 - A physician's order stated, "Patient to wear right hand comfy splint (used to ensure proper positioning during sleep). On at 2200 (10 PM) off at 0600 (6 AM) with skin checks." 5/31/18, 6/21/19 and 11/30/19 - The facility's ROM Assessments stated that the finger extension of R9's right hand was severely limited and that R9 refused or declined a splint. 8/1/18 - A written statement, completed by E12 (OT), stated that R9 had a resting hand splint, but declined to wear it or to do a trial and would not allow the therapist to range the right hand. E12 also wrote that R9 was educated on the benefits of the splint and ROM for hygiene and skin integrity, but continued to decline participation. 4/1/19 - Review of the TAR revealed that R9's right hand comfy splint was discontinued. A care plan, reviewed on 5/7/19, stated R9 had "impaired physical mobility related to decreased joint function: right finger/hand...". The care plan	F 688	updating care plan and completing documentation of interventions. The Root Cause results will be presented at the monthly QAPI meeting. All residents identified with limited range of motion will have a program developed to help maintain the residents□ current status or recommended improvement. All licensed nurses will be in-serviced by the DON/Designee to ensure that residents with limited range of motion are receiving appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion and that services provided are care planned and documented. 4. A weekly audit of the residents□ with limited range of motion medical record to ensure that the range of motion services are being conducted x 2 weeks until 100% than monthly x 2 months until 100%. Results of the audits will be presented at the monthly QAPI meeting for review and recommendations.	

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F 688	Continued From page 21	F 688		

review stated there was no change and refused splint, and a rolled up washcloth in the right hand. The care plan was again reviewed on 8/8/19 and stated there was no change and to continue the plan of care.

A care plan, last reviewed on 8/8/19, stated R9 "is non-compliant with right hand splint, removes it frequently." The care plan stated to continue with the plan of care and that the resident continues to be non-compliant. The goal of the care plan was the resident will wear splint as recommended. Interventions included to document refusals.

A care plan, last reviewed on 8/8/19, stated R9 had "impaired physical mobility related to right arm: refuses arm/hand splint." The care plan stated to continue with the plan of care. Interventions included to encourage resident to participate in ROM exercises as able, monitor for signs and symptoms of pain with ROM, and to apply a right hand comfy splint at 10:00 PM and remove at 6:00 AM. The care plan failed to identify the type of ROM exercises to be performed, and failed to identify the frequency and duration of the exercises.

A care plan, last revised on 8/8/19, stated R9 was at increased risk for actual/potential limitation in ability to perform activities of daily living. Interventions included, "resident requires splint to right hand on at 10 PM off at 6 AM non-compliant."

A care plan, last revised on 10/19/19, stated R9 had the potential for impairment to skin integrity. Interventions included to apply a right hand splint per MD order and for PT to evaluate the hand splint.

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F 688	Continued From page 22 Although the right hand comfy splint was discontinued on 4/1/19, care plans continued to state it was to be applied. 8/6/19 - A quarterly MDS assessment stated R9 had: short and long term memory problems; daily decision making skills were severely impaired; there was no rejection of care during the seven (7) day review time period; for ADLs R9 required extensive assist to total dependence on one (1) staff; and had a functional limitation in ROM of the upper extremity on one side. 9/20/19 - The facility's ROM Assessment stated that the finger extension of R9's right hand was WFL (Within Functional Limits). 9/1/19 through 10/18/19 - Review of CNA Documentation Survey Reports lacked evidence of R9 receiving any ROM exercises or that a rolled washcloth was being placed in R9's hand. 9/1/19 through 10/18/19 - Review of the TAR lacked evidence that a rolled washcloth was being placed in R9's right hand or that the resident was refusing. The following observations were made of R9: - 10/15/19 at 2:47 PM - R9 was sleeping in bed with the right hand fisted with the thumb positioned between the 2nd and 3rd fingers. There was no rolled washcloth in place in the right hand. - 10/17/19 at 8:45 AM, 9:58 AM, 11:30 AM, and 2:40 PM - R9 was positioned on her back with the right hand fisted and thumb positioned between the 2nd and 3rd fingers. There was no rolled washcloth in place in the right hand.	F 688		

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F 688	Continued From page 23 10/18/19 at 7:55 AM - During an interview, E8 (CNA) stated that R9 has one hand closed and she was "barely able to get in to clean." 10/18/19 at 12:26 PM - R9 was observed with a rolled washcloth placed in the right hand. 10/21/19 at approximately 1:30 PM - E9 (CNA) was observed by two (2) surveyors attempting to open R9's right hand. E9 was only able to open R9's hand a small amount before R9 began moaning. The skin of the palm was observed to be intact, but was moist and had a faint odor. When E9 was told about the odor, she stated, "And that's after a shower today. I got in there as much as I could." 10/21/19 at 1:32 PM - A physician's order was entered to "Apply kling roll to right hand as tolerated. Remove for skin care. Check skin integrity every shift. 10/21/19 approximately 2:00 PM - During an interview, E14 (Regional Director of Rehabilitation) stated that she was able to open R9's right hand and there were no skin issues. E14 stated that R9 did not fully extend the fingers. E14 was informed of the surveyor's observation when E9 (CNA) was only able to open R9's right hand a small amount when the resident began moaning. 10/21/19 approximately 2:15 PM - During an interview with E10 (LPN) and E2 (DON), E10 stated that she attempted to place a rolled cloth to R9's right hand this morning, but the resident refused. When she went back mid morning, R9 allowed her to place the rolled cloth. R9 later had	F 688		

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F 688	Continued From page 24 a shower so the rolled cloth was removed. E2 stated that R9's splint was discontinued due to R9's refusals. E2 stated that the facility did not have a restorative nursing program, but that CNAs complete ROM during care. The facility failed to ensure that R9, who had a limitation in ROM, received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Although ROM was identified as an intervention in R9's care plan, there was no documented evidence that it was completed. 10/22/19 approximately 5:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (Corporate Nurse), and E4 (ADON).	F 688		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	F 758		12/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085036	A. BUILDING _____ B. WING _____	10/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 25 specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the facility failed to ensure that non-pharmacological interventions were provided prior to administering an as needed (PRN) antianxiety medication, and the facility failed to ensure there was an indication for use prior to the administration of the medication for one (R2) out of five (5) residents sampled for	F 758	1. A review of R2 medication administration record will be conducted by the DON/Designee. Nurse□s identified as giving the medication without non-pharmacological interventions will be in-serviced on the appropriate interventions prior to giving psychotropic medication by DON/designee.	

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F 758	Continued From page 26 unnecessary drug reviews. Findings include: Review of the clinical record revealed the following: 8/29/14 - R2 was admitted to the facility and had a diagnosis of dementia with delusions (an unshakable belief in something untrue). 3/21/19 - R2 had a physician's order for the antianxiety medication Lorazepam to be administered orally every 8 hours as needed for anxiety (give before care). Review of the MAR for the months of September 2019 and October 2019 revealed that R2 was administered Lorazepam on 9/7/19, 9/8/19, 9/10/19, 9/22/19, 9/24/19, 9/25/19, 10/1/19, 10/2/19, 10/7/19, 10/10/19, 10/17/19, 10/18/19, 10/19/19 and 10/21/19. On six (6) of the 14 days that Lorazepam was given there were no documented behaviors on the behavior monitoring sheets or in progress notes that warranted use of the Lorazepam. Additionally, there was no evidence that non-pharmacological interventions were attempted prior to the use of Lorazepam on 12 out of the 14 days. 10/22/19 approximately 12:30 PM - Findings were reviewed with E2 (DON) and E4 (ADON). 10/22/19 5:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2, E3 (Corporate Nurse), and E4.	F 758	2. All residents receiving prn psychotropic medications will have a 90 day review to identify if the medication was given without non-pharmacological interventions. 3. A root cause analysis was conducted and the results concluded a knowledge deficit. The Root Cause Analysis will be presented at the monthly QAPI meeting. All residents receiving prn psychotropic will have non-pharmacological interventions prior to administering of PRN psychotropic medication. All licensed nurses will be in-serviced on the regulatory standards of administration of non-pharmacological interventions prior to administering prn psychotropic medication by DON/designee. 4. A weekly audit of residents□ receiving prn psychotropic medications for non-pharmacological interventions prior to administering the medication for 2 weeks until 100% then monthly x 2 months until 100%. Results of the audits will be presented to monthly QAPI for review and recommendations.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		12/22/19

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F 880	Continued From page 27 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880		

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F 880	Continued From page 28 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation, it was determined that the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility failed to have proper hand hygiene for one employee between direct resident contact during medication pass observations. Findings include: Review of the facility policy and procedure dated	F 880	1. The nurse identified was in-serviced on handwashing protocol by DON/designee. 2. All residents have the potential to be affected by this practice. License nursing staff will be observed for their handwashing technique during med pass by DON/designee. 3. A root cause analysis was conducted and determined compliance with standard was the issue. The results of the Root Cause analysis will be presented to monthly QAPI meeting. Nursing staff will	

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F 880	Continued From page 29 5/24/12 and revised on 1/17/16, entitled "Hand Washing" stated, "Hand washing is one of the most crucial measures in reducing transmission of pathogens in healthcare settings...Hand washing is performed before starting to work; when hands are visibly soiled or contaminated with blood or other body fluids; if moving from a contaminated - body site to a clean - body site during resident care; after contact with soiled or contaminated articles, such as articles that are contaminated with blood or body fluids; after contact with an object (e.g., door knobs) or source where there is a concentration of microorganisms such as mucous membranes, non-intact skin, body fluids, or wounds." Review of the "Lippincott Manual of Nursing Practice 7th Edition, 2001, stated, "Fundamentals of Standard Precautions - Hand washing is the single most important measure to reduce the risks of transmitting microorganisms; washing hands as promptly and thoroughly as possible between patient contacts; after contact with blood, body fluids, secretions, excretions, and contaminated equipment or articles..." On 10/17/19 at 8:45 AM - E6 (RN) was observed administering R36's morning oral medications. After giving R36's medications, E6 was observed going back to the medication cart in the hallway to get R36's nebulizer treatment. E6 went back to R36's room and administered R36's medication. Without washing her hands, E6 then proceeded to go back to the medication cart in the hallway and was seen opening the drawer, taking out the medication blister packs and dispensing oral medications to another resident, R38, who resided in a different room.	F 880	wash hands before and after administering Medications and treatments. License nursing will be in-serviced on proper handwashing between patients when administering Medications and treatments by DON/designee. 4. A weekly random audit observation of 4 licensed nurses passing medications for appropriate handwashing between resident contacts and as needed for 2 weeks until 100% and then monthly x 2 until 100%. Results of the audits will be presented to monthly QAPI meeting for review and recommendations.	

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F 880	Continued From page 30 On 10/17/19 at 8:52 AM - E6 was observed entering R38's room, administering oral medications and applying a topical patch on to R38's back. After administering R38's medications, E6 was then observed going into the bathroom to wash her hands. 10/17/19 at 9:20 AM - Findings were confirmed by E6. 10/22/19 at 3:20 PM - Findings were reviewed with E2 (DON) and E4 (ADON).	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to provide a safe, functional, and sanitary environment for laundry staff. Findings include: 10/22/19 at 8:35 AM - Tour of the laundry room revealed the following; Dirty laundry room; - One of two overhead lights in the room was burned out; - Both washing machine doors were dirty with soap residue; - A ceiling tile located directly over an electrical outlet showed evidence of prior water damage, and was currently bulging with water; - Multiple floor tiles were broken revealing the	F 921	1. Overhead lights in the room were replaced, both washing machine doors were cleaned of residue at the time of the survey, water that was puddled on the floor in front of one of the washers was cleared. The floor is being replaced a quote obtained and work scheduled. Roof repair has been approved, work is being scheduled, and damaged ceiling tiles were replaced. 2. All residents have the potential to be affected by this practice. Laundry room inspection will be added to the monthly environmental rounds any issues identified will be brought to the ED□s attention by maintenance director. 3. A root cause analysis was conducted	12/22/19

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F 921	Continued From page 31 concrete floor below the tile; - Water was puddled on the floor in front of one of the washers, and was observed oozing up from beneath the tiles for approximately five feet in front of both washing machines. 10/22/19 at 10:08 AM - During an interview, E7 (maintenance director) confirmed that water was behind the bulging ceiling tile. E7 stated that he had been asking corporate to repair the roof since February 2019. E7 confirmed that the water on the floor in front of the washers was due to a drain back up. The facility failed to provide a safe, functional, and sanitary environment for laundry staff. Findings were reviewed with E2 (DON) and E4 (ADON) on 10/22/19 at 3:20 PM.	F 921	and determined a preventive maintenance issue occurred for this room. The results will be presented at the monthly QAPI meeting. All environmental rounds results will be brought to the ED□s attentions for obtaining services needed. Environmental staff will be in-serviced on environmental rounding and the reporting the findings by ED/designee. 4. Environmental rounds have been scheduled monthly in ancillary areas. Preventive maintenance is scheduled for laundry area. Results of the audit will be presented at the monthly QAPI for review and if appropriate recommendations.	

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F 000	INITIAL COMMENTS An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from October 15, 2019 through October 22, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census the first day of the survey was 39. The survey sample size was 24 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; Contracture - a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints; Documentation Survey Report - a report in which CNAs document the care provided to a resident on each shift; DON - Director of Nursing; Functional Limitation in Range of Motion - limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living) or places the resident at risk of injury; Gerichair - wheelchair type- chair that reclines; Hand Hygiene - performing hand washing, antiseptic hand wash, alcohol based hand rub, surgical hand hygiene/antisepsis; Hand Washing - washing hands with plain soap or a cleaning agent and water; Kling roll - a gauze roll that is highly-absorbent, conforms to the bodies contours and moves with the bodies motions; LPN - Licensed Practical Nurse; MD - Medical Doctor;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/18/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 MDS - Minimum Data Set/standardized assessment tool used in long term care facilities; Nebulizer - an electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece; Nebulizer Treatment- changes liquid medication into fine mist to breathe directly into lungs; NHA - Nursing Home Administrator; OT - Occupational Therapy/Therapist; PT - Physical Therapy; PTA - Physical Therapy Assistant; RD - Registered Dietitian; RN - Registered Nurse; ROM - Range of Motion; Systolic Blood Pressure (SBP) - the top number of the blood pressure reflects pressure in vessels when the heart is beating; TAR - Treatment Administration Record.	F 000		

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E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from October 15, 2019 through October 22, 2019. The facility census the first day of the survey was 39. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were cited.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/18/2019

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.

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Forwood Manor
October 22, 2019

DATE SURVEY COMPLETED:

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from October 15, 2019 through October 22, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census the first day of the survey was 39. The survey sample size was 24 residents. Abbreviations/definitions used in this report are as follows: ADON – Assistant Director of Nursing; CDC - Center for Disease Control; CNA – Certified Nurse's Aide; DON – Director of Nursing; NHA – Nursing Home Administrator; RN – Registered Nurse. This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed October 22, 2019:F550, F607, F636, F656, F657, F679, F684, F688, F758, F880, and F921.		
3201 3201.6.0 3201.6.9 3201.6.9.2	Regulations for 3201 Skilled and Intermediate Care Nursing Facilities Services To Residents		

Provider's Signature Karen J Painter Title Ex Director Date 12/19/19

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
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NAME OF FACILITY: Forwood Manor
October 22, 2019

DATE SURVEY COMPLETED:

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201.6.9.2.4	Communicable Diseases Specific Requirements for Tuberculosis Minimum requirements for pre-employment tuberculosis (TB) testing require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as Quanti Feron. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category. Based on review of employee TB screening and interview, it was determined that the facility failed to ensure that for two (E19 and E20) out of 10 employees reviewed, pre-employment TST was not completed. Findings include: 1. E19 was hired on 9/17/19. Documentation revealed that E19 had the first step TST on 7/10/19. There was no documented evidence that a second step TST was completed.	No resident's or staff was adversely affected by this practice. Employee E19 is no longer employed by the facility. E20 has tested negative for TB. First Step given 7/11/19 results 0mm. Second step 7/19/19 results 0mm All residents have the potential to be affected by this practice. All employee files have been	12/05/2019

Provider's Signature Karen P Painter Title Ex. Director Date 12/19/19

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NAME OF FACILITY: Forwood Manor
October 22, 2019

DATE SURVEY COMPLETED:

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	2. E20 was hired on 7/25/19. Documentation revealed that E20 did not have any TST completed.	audited by the HR Manager to ensure pre -employment TST was completed. All files are in compliance.	
TITLE 16	10/22/19 5:30 PM – Findings were reviewed with E1 (NHA), E2 (DON), E3 (Corporate Nurse), and E4 (ADON) during the exit conference.	A root cause analysis was conducted and we identified a communication issue occurred that resulted in the test results not being given to Forwood Manor for inclusion in the employees personnel file.	
CHAPTER 11 Subchapter IV § 1144	Delaware Code Health and Safety Regulatory Provisions Concerning Public Health Long-Term Care Facilities and Services. Criminal Background Checks; Mandatory Drug Screening; Long-Term Care Facilities; Nursing Home Compliance with Title XIX of the Social Security Act. Influenza immunizations. (a) Nursing and assisted living facilities shall annually offer, beginning no later than October 1 and extending through March 1 of a calendar year, onsite vaccinations for influenza vaccine to all employees with direct contact with patients at no cost and contingent upon availability of the vaccine.	Human Resource and Department Heads will be in-serviced by the ED/designee on the importance of all employees having pre hire TST completed and included in the employee file. New employee files will be audited by the HR Manager monthly until 2 months of 100% compliance to confirm that pre hire TST was completed. Results of the audit will be presented at the monthly QAPI meeting for review and recommendations.	
	(b) The facility shall keep on record a signed statement from each employee stating that the employee has been offered vaccination against influenza and has either accepted or declined	No resident's or staff was adversely affected by this practice. All residents have the potential	12/05/2019

Provider's Signature Karen Painter Title Ex Director Date 12/19/19

DELAWARE HEALTH
AND SOCIAL SERVICES
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Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

NAME OF FACILITY: Forwood Manor
October 22, 2019

DATE SURVEY COMPLETED:

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	such vaccination. (c) Employment will not be contingent on influenza immunization. Based on review of facility employee flu immunizations and staff interview, it was determined that for five (E11, E17, E18, E21, and E22) out of five employees sampled the facility failed to offer onsite vaccinations of influenza vaccines. Findings include: During an interview on 10/22/19 at approximately 5:30 PM, E2 (DON) and E3 (Corporate Nurse) stated that the facility does not offer employee flu vaccines onsite. E2 and E3 stated that employees are instead given a voucher to take to a pharmacy to obtain their flu vaccines. E2 and E3 stated that the facility follows CDC recommendations for the flu vaccine to be obtained anytime from October 1st through March 1st. They stated there was no facility policy regarding a cutoff date by which the employees were required to obtain the vaccine. Review of facility documentation revealed that E17 (RD) had declined the flu vaccine and completed the refusal/consent form on 10/21/19 after the survey team requested the data. Data provided for E11 (Activity Assistant), E18 (RN), E21 (CNA), and E22 (CNA) revealed "Have not received vaccination as of yet."	to be affected by this practice. Employees will be offered influenza vaccines on site. All Department Heads will be in serviced by the Executive Director/designee. All employee files have been audited by the HR Manager to ensure Flu vaccine vouchers were offered. The HR Manager will develop a list of employees who have not received the vaccine and Department Heads/designees will follow up with their staff to ensure compliance with regulation and policy. A root cause analysis was conducted and determined a knowledge deficit regarding administration location requirements and timeliness of administration. Employees will be in-serviced by the DON/designee on the revised vaccine policy. All new employee files will be audited for a minimum of 2 months until 100% compliance achieved & then quarterly x 2 until 100% compliance. Employees must show evidence facility of flu vaccines by October 31 every year	

Provider's Signature Karen P Painter Title Ex Director Date 12/19/19

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
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STATE SURVEY REPORT

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	The facility failed to ensure that employees were offered influenza vaccines onsite. Findings were reviewed with E1 (NHA), E2 (DON), E3 (Corporate Nurse), and E4 (ADON) on 10/22/19 at approximately 5:30 PM.	Results will be presented at the monthly QAPI meeting for review and recommendations.	

Provider's Signature Karen J Painter Title Ex Director Date 12/19/19