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 _____	C 01/14/2021

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 COVID-19 Focused Infection Control and Complaint Survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection from January 8, 2021 through January 14, 2021. The facility was found to not be in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The facility census on the first day of the survey was 32. The survey sample totaled seven (7) residents, including two (2) closed records. Abbreviations/definitions used are as follows: ADON - Assistant Director of Nursing; CDC - Centers for Disease Control and Prevention; CMS - Center for Medicare and Medicaid Services; DON - Director of Nursing. COVID-19/Coronavirus - a respiratory illness that can be spread person to person.	F 000		
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 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		2/18/21

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

Electronically Signed | 01/31/2021

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 684	Continued From page 1 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, interviews and review of facility and other documentation, it was determined that for one (R1) out of three sampled residents for physician's orders, the facility failed to follow the physician's order to be NPO (nothing by mouth) for a procedure which resulted in the appointment being rescheduled. Findings include: Review of R1's clinical record revealed: 9/2/20 - R1 was admitted to the facility. R1's diagnoses included: complicated urinary tract infection, acute kidney infection and stent placement with a history of ureteral stent (small tube inserted into the tube or duct between the kidney and the bladder) occlusion (obstruction) with migration (movement). 10/13/20 - R1 had a physician's order entered to be NPO after 12 midnight on 10/29/20 for a "procedure" that was discontinued on 10/23/2020. The order for NPO status was not reordered. 10/13/20 at 1:29 PM - A nurse progress note documented, "Resident for a f/u (follow up) visit to urologist (physician that specializes in disorders of the urinary tract)...". 10/29/20 at 4:34 PM - A nurse progress note documented that R1's procedure was canceled, "...and resident didn't have/follow (sic) NPO status as expected...ate about 50% of breakfast prior to the appointment...". 10/30/20 - A physician's progress note,	F 684	F684 483.25 – Quality of Care 1. R1 is no longer resides in the facility and suffered no untoward affect related to the deficient practice. R1 subsequently had a successful procedure. 2. All residents readmitted with existing NPO for procedure orders may be affected. 3. Licensed staff with be in-serviced regarding review of previously existing NPO for procedure orders. Review of admission orders will occur by the IDT to en-sure appropriate orders are enacted. Process of medication reconciliation for readmission of residents will be in-serviced and enacted. 4. DON and/or designee will audit all NPO orders for accuracy Daily * 14 days until 100% compliance met, weekly * 2 weeks until 100% compliance met, monthly until 100% compliance met. Then monthly * 2 months until 100% compliance and report findings through QA. Date certain 2/18/21	

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F 684	Continued From page 2 assessment and plan for R1's ureteral stent occlusion included followup for a stent with the procedure scheduled for mid-November. 1/14/21 at 3:50 PM - When asked why the physician's order, dated 10/13/20, for R1 to be NPO after 12 midnight on 10/29/20 was discontinued on 10/23/20, in an email correspondence, E1 (DON) replied, "I can't speak to how it was discontinued, however I see the MAR (medication administration record) and order reflect the discontinuation." 1/14/21 - Findings were discussed with E1. 1/14/21 at approximately 4:20 PM - Findings were reviewed with E1, E2 (Interim DON) and E3 (ADON) during the Exit Conference.	F 684		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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,	F 880		2/18/21

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F 880	Continued From page 3 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 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.	F 880		

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F 880	Continued From page 4 §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 other documentation as indicated, it was determined that the facility failed to thoroughly screen employees and visitors prior to their entrance into the facility. Findings include: Review of the CDC's Infection Control Guidance, dated 7/15/2020, stated, "...Screen everyone (patients, health care personnel, visitors) entering the healthcare facility for symptoms consistent with COVID-19 or exposure to others with SARS-CoV-2 infection and ensure they are practicing source control. Actively take their temperature and document absence of symptoms consistent with COVID-19...." (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control recommendation/html). Review of the facility policy for Coronavirus (COVID-19), last updated 12/9/2020, stated, "Screenings are conducted and documented using the applicable screening tool...All team members are screened for fever and /or respiratory symptoms. Essential visitors, vendor, and third party contractors are screened prior to entry into the community [facility]." 1/8/21 at 11:00 AM - Review of the facility's visitor screening tool and log revealed two (2) outside	F 880	F880 Infection Control 1. No Specific Individual/Resident was impacted by Deficiency. 2. All residents have the potential to be affected by this practice but no other specific individuals were identified. 3. All trained screeners will be re-inserviced and educated specifically on deficiency examples of documentation showing lack of evidence of protocols. Screening Tool and Log, Screening Guide-lines and Covid Policy PRO 4027 meeting CMS requirements for infection control standards. Documentation will be maintained on the training and competency on all screeners. Appropriate actions are being taken with at least one associate identified as showing incomplete documentation on our internal audit. 4. Increased frequency and duration of QAA will be maintained by Executive Director and/or designee Daily in order to	

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F 880	Continued From page 5 visitors visited the facility on 12/17/20. The facility lacked evidence that each visitor completed the facility's COVID-19 Screening Tool which included temperature checks, signs and symptoms screening and exposure questions. 1/8/21 at 12:00 PM - Review of the facility's team member screening tool and logs dated 12/2/20 through 12/25/20, revealed that temperatures were not consistently taken for all facility staff and the facility lacked evidence that signs/symptoms and exposure risks for COVID-19 were complete. 1/8/21 at 2:30 PM - In an interview, E2 (Interim DON) confirmed that the screening logs should have been completed every time visitors and facility staff enter the facility. 1/14/21 at 4:20 PM - Findings were reviewed during the exit with E1 (DON), E2 (Interim DON) and E3 (ADON).	F 880	verify successful implementation of screening process: * 30 days un-til 100% compliance, 3* week for 2 weeks until 100% compliant, weekly * 2 weeks until 100% compliant, then monthly until 100% compliant. Date certain 2/18/21	

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 **DATE SURVEY COMPLETED: January 14, 2021**

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 COVID-19 Focused Infection Control and Complaint Survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection from January 8, 2021 through January 14, 2021. The facility was found to not be in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The facility census on the first day of the survey was 32. The survey sample totaled seven (7) residents including 2 closed records.	Cross Refer CMS 2567-L survey completed January 14, 2021: F684 and F880 Submitted EPOC on 1/31/21	2/18/21
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by:		

Provider's Signature _____ Title **Executive Director** Date **1/31/21**

DELAWARE HEALTH AND SOCIAL SERVICES
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STATE SURVEY REPORT

NAME OF FACILITY: Forwood Manor **DATE SURVEY COMPLETED: January 14, 2021**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Cross Refer to the CMS 2567-L survey completed January 14, 2021: F684 and F880.		2/18/21

Provider's Signature _____ Title _____ Date _____