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

DHSS - DHCQ
Cambridge Building
263 Chapman Road Suite 200
Newark, DE 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: AL-Forwood Manor Assisted Living **DATE SURVEY COMPLETED:** August 7, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual and Complaint Survey was conducted at this facility from August 6, 2024 through August 7, 2024. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was twenty-five (25). The survey sample totaled five (5) residents, plus three additional subsampled residents. Abbreviations/definitions used in this state report are as follows:		
	Contract – A legally binding written agreement between the facility and the resident which enumerates all charges for services, materials, and equipment, as well as non-financial obligations of both parties, as specified in the State regulations; CG – Caregiver; DRC – Director of Resident Care; EMR – Electronic Medical Record; LPN – Licensed Practical Nurse; NHA – Nursing Home Administrator; Resident Assessment – evaluation of a resident's physical, medical, and psychosocial status as documented in a Uniform Assessment Instrument (UAI), by a Registered Nurse; RN – Registered Nurse; SA (Service Agreement)– allows both parties involved (the resident and the assisted living facility) to understand the types of care and services the assisted living provides. These include: lodging, board, housekeeping, personal care, and supervision services;		

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3225.0	**Assisted Living Facilities**		
3225.8.0	**Medication Management**		
3225.8.3	**Medication stored by the assisted living facility shall be stored and controlled as follows:**		
3225.8.3.1	**Medication shall be stored in a locked container, cabinet, or area that is only accessible to authorized personnel;**		
3225.8.3.2	**Medication that is not in locked storage shall not be left unattended and shall not be accessible to unauthorized personnel;** This requirement was not met as evidenced by: Based on observation, it was determined that three medication carts located in the hallway were left unlocked and unattended. Findings include: 8/7/24 at approximately 7:25 AM, the Surveyor met E15 (LPN) coming out of a resident's room and we both walked to where the medication carts were located down another hall, past the common area. On arrival, the Surveyor noted all three medication carts were left unlocked and unattended. At approximately 7:35 AM during the next medication administration, E15 locked two of the three carts and started walking down the hall. The Surveyor asked E15 if the third cart should be locked, E15 turned and did lock the third cart prior to leaving. 8/7/24 – Findings were reviewed with E1 (NHA), E2 (DRC) and R3 (Regional RN) at the	A. There were no residents negatively impacted by this deficient practice. All med techs and nurses, including E15, will be in serviced by the DRC, no later than September 5, 2024, on the need to lock unattended medication carts. See Attachment A – In service attendance sheet. B. All residents are at risk of being affected by this deficient practice. C. Upon each med pass, the nurse/med tech will lock the med cart when the cart is unattended. All nurses and med techs have been trained. D. The Director of Resident Care/ designee will randomly check 3 medication carts during medication pass once daily for 2 weeks. If this process is successful, the audit will occur Weekly x4 then	September 5, 2024

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	exit conference beginning at approximately 11:05 AM.	bimonthly x2, monthly until 100% compliance is achieved. See Attachment B – Med Cart Audit Sheet.	
3225.9.0	**Infection Control**		
3225.9.5	**Requirements for tuberculosis and immunizations:**		
3225.9.5.2	**Minimum requirements for pre-employment 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 QuantiFeron. 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.** This requirement was not met as evidenced by: Based on record review and review of other facility documentation, it was determined that for four (E5, E7, E11 and E12) out of six employees sampled, the facility failed to provide evidence of the pre-employment tuberculin testing. Findings include:	A. There were no residents negatively impacted by this deficient practice. E5, E7, E11 and E12 will be removed from the schedule until the two step PPD process has been completed for each employee and their respective employee records have been updated. B. All residents are at risk of being affected by this practice. C. Upon start date, all new hire employees will have had negative TB test results recorded on the PPD Log – Attachment C. Each employee file will be updated to reflect negative results. D. With every new hire, the Business Office Manager/HR will verify each employee has a negative TB result. The ED/designee will audit the findings weekly times four weeks then monthly times	September 30, 202

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	1. 10/17/22 – E5 (Program Director) was hired. The facility had no evidence of the tuberculin testing. 2. 12/5/23 – E7 (Security) was hired. The facility had no evidence of the tuberculin testing. 3. 6/12/23 – E11 (CG) was hired. The facility had no evidence of the tuberculin testing. 4. 7/30/24 – E12 (Dishwasher/Utility) was hired. The facility had no evidence of the tuberculin testing. 8/7/24 – Findings were reviewed with E1 (NHA), E2 (DRC) and R3 (Regional RN) at the exit conference beginning at approximately 11:05 AM.	two months until 100% compliance is achieved.	
3225.10.0	**Contracts**		
3225.10.10	**No contract shall be signed before a full assessment of the resident has been completed and a service agreement has been executed. If a deposit is required prior to move-in, the deposit shall be fully refundable if the parties cannot agree on the services and fees upon completion of the assessment.** This requirement was not met as evidenced by: Based on record review and review of other facility documentation, it was determined	A. There were no residents negatively impacted by this deficient practice. R1 and R2 Service Agreements were reviewed and determined to be accurate. B. All residents are at risk of being affected by this deficient practice. C. Upon admission, all residents will have a signed Service Agreement in their medical record before	August 28, 2024

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	that for two (R1 and R2) out of four residents sampled for contracts, the facility failed to complete the SA prior to the contract being signed. Findings include: 1. 6/6/24 – R1 was admitted to the facility. The Service Agreement was completed on 6/6/24 and the contract was signed on 5/31/24, prior to the SA being executed. 2. 11/28/23 – R2 was admitted to the facility. The Service Agreement was completed on 11/28/23 and the contract was signed on 11/10/23, prior to the SA being executed. 8/7/24 – Findings were reviewed with E1 (NHA), E2 (DRC) and R3 (Regional RN) at the exit conference beginning at approximately 11:00 AM.	the contract is signed. Each resident medical record will be updated to reflect a signed contract post Service Agreement. D. Staff was in-serviced by the Director of Resident Care, to ensure there is a signed and accepted Service Agreement before initiating contract signing. All Service Agreements and contracts will be signed on the same day with the addition of "copies provided to signer" written on the original and will be initialed and dated by Director of Resident Care/designee. The ED/designee will audit new resident Medical Records weekly times 4 weeks then monthly times 2 months until 100% compliance is achieved.	
3225.12.0 3225.12.1 3225.12.13	**Services** **The assisted living facility shall ensure that:** **Food service complies with the Delaware Food Code** **Delaware Food Code** Based on observations, interview, and review of other facility documentation it was determined that the facility failed to comply with the Delaware Food Code. Findings include: **Delaware Food Code 3-401.11 Raw Animal Foods: (A) Except as specified under (B) and**	A. There were no residents negatively impacted by this deficient practice. An in-service was done by the Director of Dining Services, on the temperature log was completed on August 6,	August 19, 2024

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	in (C) and (D) of this section, raw animal FOODS such as EGGS, FISH, MEAT, POULTRY, and FOODS containing these raw animal FOODS, shall be cooked to heat all parts of the FOOD to a temperature and for a time that complies with one of the following methods based on the FOOD that is being cooked. 8/6/24 – 1:00 PM - During the survey of the facility, review of requested food temperature logs, the facility was missing 45 mealtime temperatures out of 189 reviewed between May 1, 2024 – June 30, 2024.	2024. See Attachment D – In Service sign off with curriculum for the training. B. All residents are at risk of being affected by this deficient practice. C. Food temps are recorded on the daily temperature sheet. See Attachment E – Temp Log. D. The Dining Director/designee will audit the perishable food daily times two weeks then weekly times eight weeks until 100% compliance is achieved. See Attachment F – Audit sheet for opened/expired/perishable food.	
	3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking: (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in ¶¶ (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. 8/6/24 – 11:00 AM During the initial inspection of the kitchen with E4 (Director of Food and Dining Services), Two bags of opened cheese cubes and in zip-lock bags, and a package of opened scrapple wrapped in	A. There were no residents negatively affected by this deficient practice. Dining staff was in serviced on August 6, 2024 regarding opened food label and dating. An immediate audit was performed by the dining Director/designee. B. All residents are at risk of being affected by this practice. C. All food will be labeled and dated on the day it is opened. D. The Dining Director/designee will audit the opened food daily times two weeks then weekly times eight weeks or until 100%	August 19, 2024

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	plastic wrap were found inside the walk-in refrigerator but were not dated as to when opened.	compliance is achieved. See Attachment F – Audit sheet for opened and expired food.	
	3-701.11 Discarding or Reconditioning Unsafe, Adulterated, or Contaminated Food. (A) A FOOD that is unsafe, ADULTERATED, or not honestly presented as specified under § 3-101.11 shall be discarded or reconditioned according to an APPROVED procedure. 8/6/24 – 11:00AM During the initial inspection of the kitchen with E4 (Director of Food and Dining Services), two spaghetti squash were observed with mold growing on them. 8/6/24 – Findings were discussed with E4 at 1:30 PM, and with E2 (DRC) at 2:45 PM.	A. There were no residents negatively affected by this deficient practice. Dining staff was in serviced by the Dining Director, on August 6, 2024 regarding expired food. An immediate audit was performed by the dining Director/designee. B. All residents are at risk of being affected by this practice. C. All perishable food will be monitored and assessed for spoilage daily. D. The Dining Director/designee will audit the perishable food daily times two weeks then weekly times eight weeks until 100% compliance is achieved. See Attachment F – Audit sheet for opened/expired/perishable food.	August 19, 2024
3225.13.0 3225.13.1	**Service Agreements** **A service agreement based on the needs identified in the UAI shall be completed prior to or no later than the day of admission. The resident shall participate in the development of the agreement. The resident and the facility shall sign the agreement and each shall receive a copy of the signed agreement. All persons who sign the agreement must be able to comprehend and perform their obligations under the agreement.**		

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	This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for five (R1, R2, R3, R7 and R8) out of five sampled residents for the SA completion, the facility failed to provide evidence that the resident or family participated in the development of the agreement or that the resident was provided a copy. Findings include: 1. 6/6/24 – R1 was admitted to the facility. The Service Agreement was completed on 6/6/24. The SA was not signed by the resident/family and there was no evidence a copy was given to the resident/family. 2. 11/28/23 – R2 was admitted to the facility. The Service Agreement was completed on 11/28/23. The SA was not signed by the resident/family and there was no evidence a copy was given to the resident/family. 3. 4/22/24 - R3 was admitted to the facility. The Service Agreement was completed on 4/22/24. The SA was not signed by the resident/family and there was no evidence a copy was given to the resident/family. 4. 7/19/21 - R7 was admitted to the facility. The last Service Agreement was completed on 5/1/24. The SA was not signed by the resident/family and there was no evidence a copy was given to the resident/family.	A. There were no residents negatively impacted by this deficient practice. B. All residents are at risk of being affected by this deficient practice. C. Post August 22, 2024, prior to admission and every six months thereafter, all residents will be offered a signed Service Agreement. The agreement will be placed in their medical record. Each resident medical record will be updated to reflect a signed contract post Service Agreement. Each resident/family will be given a signed copy of the Service Agreement. D. The Director of Resident Care/ designee will randomly check Service Agreements for signatures and distribution to Resident/Family, daily for 1 week then bi-weekly x 4 then monthly x 2 until 100% compliance is achieved.	September 16, 202

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	5. 3/7/24 - R8 was admitted to the facility. The Service Agreement was completed on 3/7/24. The SA was not signed by the resident/family and there was no evidence a copy was given to the resident/family. 8/7/24 - Per interview with E2 (DRC) at approximately 10:55 AM, E2 stated the SA is completed the day of admission in the EMR, the resident does not sign the SA and residents are not provided a copy of the SA unless they request it. 8/7/24 – Findings were reviewed with E1 (NHA), E2 and R3 (Regional RN) at the exit conference beginning at approximately 11:00 AM.		
3225.13.3	**The resident's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number.** This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for five (R1, R2, R3, R7 and R8) out of five sampled residents for SA completion, the facility failed to provide evidence that the service agreement contained the resident's personal Attending Physician(s) name, address and telephone number. Findings include:	A. There were no residents negatively impacted by this deficient practice. The Service Agreement for R1, R2, R3, R7 and R8 have been updated to reflect the resident's personal Attending Physician(s) name, address and telephone number. B. All residents are at risk of being affected by this deficient practice. C. Upon admission, all resident Service Agreements will include the resident's personal Attending Physician name, address and telephone number.	August 20, 2024

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	1. 6/6/24 – R1 was admitted to the facility. The Service Agreement was completed on 6/6/24. The SA did not contain the resident's personal Attending Physician's address or phone number. 2. 11/28/23 – R2 was admitted to the facility. The Service Agreement was completed on 11/28/23. The SA did not contain the resident's personal Attending Physician's address or phone number. 3. 4/22/24 - R3 was admitted to the facility. The Service Agreement was completed on 4/22/24. The SA did not contain the resident's personal Attending Physician's address or phone number. 4. 7/19/21 - R7 was admitted to the facility. The last Service Agreement was completed on 5/1/24. The SA did not contain the resident's personal Attending Physician's address or phone number. 5. 3/7/24 - R8 was admitted to the facility. The Service Agreement was completed on 3/7/24. The SA did not contain the resident's personal Attending Physician's address or phone number. 8/7/24 - Per interview with E2 (Regional RN) at approximately 10:55 AM, E2 stated the SA form in use does not contain the Physician's address or phone number. 8/7/24 – Findings were reviewed with E1 (NHA), E2 (DRC) and R3 at the exit conference beginning at approximately 11:00 AM.	D. The Director of Resident Care/designee will audit the Medical Records weekly x 2 months until 100% compliance is achieved.	
3225.18.0	Emergency Preparedness		

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3225.18.3	**Each facility shall develop and maintain all-hazard emergency plans for evacuation and sheltering in place. The plan must be submitted to the Division and DEMA in a digital format and it must conform to the template prescribed by the Division. The all-hazard emergency plan must include plans to address staffing shortages and facility demands.** 08/06/24 – During the survey of the facility, review of the Emergency Operations Manual, the manual does not include names and contact information for resident Physicians and the Office of the State LTC Ombudsman.	A. There were no residents negatively impacted by this deficient practice. Resident Physician names and the Office of the State LTC Ombudsman have been added to the Emergency Operations Manual. B. All residents are at risk of being affected by this deficient practice. C. Upon admission, names and contact information for resident Physicians and the Office of the State LTC Ombudsman will be added to the Emergency Operations Manual. D. The ED/designee will audit all current resident names with contact information for Attending Physician, address and telephone number in the Emergency Preparedness Manual until 100% compliance is achieved.	August 20, 2024
3225.18.4	**The staff on all shifts shall be trained on emergency and evacuation plans. Evacuation routes shall be posted in a conspicuous place at each nursing station.** This requirement was not met as evidenced by: Based on review of facility documentation, it was determined that four (E5, E7, E8 and E14) out of six employees' training record review, the facility failed to provide Emergency Preparedness education. Findings include: 1. 10/17/22– E5(Activities Director) was hired. The facility had no Emergency Preparedness training in evidence.	A. There were no residents negatively impacted by this deficient practice. E5, E7, and E14 are scheduled for Emergency Preparedness education to be completed no later than September 16, 2024 by the Executive Direc-	September 16, 202

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	2. 12/5/23 – E7 (Security) was hired. The facility had no Emergency Preparedness training in evidence. 3. 10/10/22 – E8 (LPN) was hired. The facility had no Emergency Preparedness training in evidence. 4. 12/2/22 – E14 (LPN) was hired. The facility had no Emergency Preparedness training in evidence. 8/7/24 – Findings were reviewed with E1 (NHA), E2 (DRC) and R3 (Regional RN) at the exit conference beginning at approximately 11:00 AM.	tor/Relias. E8 is out of the country and will complete this by 10/31/2024. Their education records will be updated upon completion. B. All residents are at risk of being affected by this deficient practice. C. Upon hire, employees receive new hire orientation which includes Emergency Preparedness training. D. HR/designee will audit all current employee training records to verify each employee's completion of Emergency Preparedness training. Any employee that has not completed the training will do so by September 16. HR/designee will audit the findings weekly times 4 weeks then monthly until 100% compliance is achieved.	

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