### 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.

#### SUMMARY STATEMENT OF DEFICIENCIES

<table>
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<tr>
<th>ID</th>
<th>PREFIX TAG</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
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<tr>
<td>F 684</td>
<td>Quality of Care</td>
<td>F 684</td>
<td>2/18/21</td>
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§ 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

**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

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.
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 flu (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,
FORWOOD MANOR

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<th>COMPLETION DATE</th>
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<td>F684</td>
<td>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.</td>
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<td>F880</td>
<td>Infection Prevention &amp; 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,</td>
<td>F880</td>
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<td>2/18/21</td>
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<td>F 880</td>
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<td>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;</td>
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§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  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 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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<tr>
<td>F 880</td>
<td>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.</td>
<td>F 880</td>
<td>verify successful implementation of screening process: * 30 days un-till 100% compliance, 3* week for 2 weeks until 100% compliant, weekly * 2 weeks until 100% compliant, then monthly until 100% compliant.</td>
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<td>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.</td>
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<td>Date certain 2/18/21</td>
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<td>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.</td>
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<td>1/14/21 at 4:20 PM - Findings were reviewed during the exit with E1 (DON), E2 (Interim DON) and E3 (ADON).</td>
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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.

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<tr>
<td>3201</td>
<td>Regulations for Skilled and Intermediate Care Facilities</td>
<td>Cross Refer CMS 2567-L survey completed January 14, 2021: F684 and F880</td>
<td>2/18/21</td>
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<tr>
<td>3201.1.0</td>
<td>Scope</td>
<td>Submitted EPOC on 1/31/21</td>
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<tr>
<td>3201.1.2</td>
<td>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:</td>
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Provider's Signature ________________________________ Title ___________ Date ___________
**NAME OF FACILITY:** Forwood Manor  
**DATE SURVEY COMPLETED:** January 14, 2021

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