DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Suite 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Forwood Estates Assisted Living

DATE SURVEY COMPLETED: August 20, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Annual and Complaint Survey was conducted at this facility from August 19, 2026, to August 20, 2026. 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 nineteen (19). The survey sample totaled eight (8) residents. Abbreviations/definitions used in this state report are as follows: CSD - Culinary Services Director; DNR – Do Not Resuscitate; ED – Executive Director; EMR – Electronic Medical Record; ESD - Environmental Services Director; FBD – Food and Beverage Director; HSD – Health Services Director; LPN – Licensed Practical Nurse.		
3225.0	**Assisted Living Facilities**		
3225.1.0	**Purpose** **The Department of Health and Social Services is issuing these regulations to promote and ensure the health, safety, and well-being of all residents of assisted living facilities. These regulations are also meant to ensure that service providers will be accountable to their residents and the Department, and to differentiate assisted living care from skilled nursing care. The essential nature of assisted living is to offer living arrangements to medically stable persons who do not require skilled nursing services and supervision. The regulations establish the**		

Provider's Signature Crystal Machen Title Executive Director Date 9/18/26

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	minimal acceptable level of services for residents of assisted living facilities.	It was identified that the UAI wasn't completed prior to resident RS transitioning from IL to AL and that it was completed on the same day by the RN. Prior to a resident moving-in; an UAI assessment will be completed and will be approved by the HSD and the ED or designee. Re-education was done by the Executive Director. No residents were affected, and this will be monitored by the HSD and the ED or designee until 100% compliance met.	8/24/2026
3225.11.0 **3225.11.2** **S/S – D**	**Resident Assessment** **A resident seeking entrance shall have an initial UAI-based resident assessment completed by a registered nurse (RN) acting on behalf of the assisted living facility no more than 30 days prior to admission. In all cases, the assessment shall be completed prior to admission. Such assessment shall be reviewed by an RN within 30 days after admission and, if appropriate, revised. If the resident requires specialized medical, therapeutic, nursing services, or assistive technology, that component of the assessment must be performed by personnel qualified in that specialty area.** This requirement was not met as evidenced by: Based on record review and interview, it was determined that for one (R5) out of three residents sampled for initial UAI assessments, the facility lacked evidence that the initial UAI assessment was completed before admission. Findings include: 7/21/26 – R5 was admitted to the facility. The initial UAI-based resident assessment was completed on the day of admission, not within the 30 days before admission per regulation. 8/20/26 2:30 PM – During an interview, E2 (HSD) confirmed the initial UAI was completed the day of admission when R5 moved from the IL to the AL setting.		

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	8/20/26 – Findings were reviewed with E1 (ED) and E2, E3 (BOM/HR), and E9 (RCD) at the exit conference beginning at approximately 4:00 PM.		
3225.12.0	**Services**	Temperature logs for the month of June, July, and August for breakfast, lunch and dinner were missing. Temperature logs are being recorded and monitored daily for accuracy. The dish machine has a thermometer reading on the outside but there was no thermometer inside the dishwasher. That has since been corrected and thermometer was bought and placed inside the dish machine reading at corrected temperature. The can opener has been taken apart and cleaned weekly. Culinary Services Director provided education to all dietary staff on 8/20/26 on food safety, cleaning equipment, and temperatures. No residents were affected, and this will be monitored by the ED and CSD or designee until 100% compliance has met.	8/20/2026
3225.12.1	**The assisted living facility shall ensure that:**		
3225.12.13	**Food service complies with the Delaware Food Code**		
	4458 State of Delaware Food Code Regulations		
3225.12.2.0	**Adoption of United States Public Health Service 2022 Food Code**		
3225.12.2.1 **S/S – F**	**The State of Delaware Food Code adopts, as if fully set forth in this regulation, the United States Public Health Service 2022 Food Code**		
	2022 Food Code U.S Food and Drug Administration		
	Chapter 3. Food 3-402.12 Records, Creation and Retention. Records must be maintained to verify that the critical limits required for food safety are being met. Records provide a check for both the operator and the regulator in determining that monitoring and corrective actions have taken place.		
	Chapter 4 Equipment, Utensils, and Linens 4-302 Utensils, Temperature Measuring Devices, and Testing Devices 4-302.13 Temperature Measuring Devices, Manual and Mechanical Warewashing. (B) In hot water me-		

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	chanical WAREWASHING operations, an irreversible registering temperature indicator shall be provided and readily accessible for measuring the UTENSIL surface temperature. **4-6 Cleaning of Equipment and Utensils 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch.** Based on observations and facility document review, it was determined that the facility failed to comply with the Delaware Food Code. Findings include: 8/20/26 – During the survey of the facility, at approximately 2:45 PM, a review of food temperature documentation provided by E4 (CSD), revealed missing food temperature logs in the month of June and July. A total of one hundred twenty-three meals were reviewed for temperature monitoring. Fifty-six meals did not have temperature documentation or were unavailable for viewing. As a result, 46% of meals did not have temperature documentation available. 8/20/26 – During the survey of the facility, at approximately 2:00 PM, the surveyor requested E4 to measure the dish surface temperature inside the dish washing machine. An irreversible registering temperature indicator was unavailable. 8/20/26 - During the survey of the facility, at approximately 2:00 PM, an observation of		

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	the kitchen can openers revealed visible debris on one out of two can openers. 8/20/26 – Findings were confirmed with E4, at approximately 3:50 PM. 8/20/26 – Findings were reviewed with E1 (ED) and E2 (HSD), E3 (BOM/HR), and E9 (RCD) at the exit conference beginning at approximately 4:00 PM.	It was identified that in an Independent Living laundry room that a utility sink had flies behind the washing machine. This was not a used Assisted Living laundry room, but Ecolab, pest control came out on 9/11/2026 and treated for insects. We have scheduled Ecolab to come and treat the IL laundry room monthly. No residents were affected, and this will be monitored by the ED and the Maintenance Director or designee until 100% compliance is met.	9/11/2026
3225.12.5	**The assisted living facility shall ensure that laundry and housekeeping services are offered and that all areas of the facility are maintained in a clean and orderly condition.** Based on observations, it was determined that the facility failed to maintain the laundry area in a clean condition. Findings include: 8/20/26 – During the survey of the facility, at approximately 2:00 PM, a review of the laundry area revealed a utility sink with residue built up inside and flying insects near the utility sink and behind the washing machines. 8/20/26 – Findings were confirmed with E6 (ESD) at approximately 2:00 PM. 8/20/26 – Findings were reviewed with E1 (ED) and E2 (HSD), E3 (BOM/HR), and E9 (RCD) at the exit conference beginning at approximately 4:00 PM.		
3225.18.0	**Emergency Preparedness**	It was identified that on April 21, 2026, that the list of attendees was not completed and I have attached it.	8/24/2026

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3225.18.2 S/S – F	**Regular fire drills shall be held at least quarterly on each shift. Written records shall be kept of attendance at such drills.** Based on document review, it was determined that the facility failed to comply with the record of attendance requirements and holding the drills quarterly on each shift. Findings include: 8/20/26 – During the survey of the facility, at approximately 3:45 PM, the surveyor reviewed requested fire drill records. A review of fire drill records beginning January 2026, with dates and shifts of records provided, included: January 20, 2026, on 7-3 shift April 21, 2026, on 7-3 shift May 5, 2026, on 3-11 shift June 6, 2026, on 11-7 shift July 19, 2026, on 7-3 shift August 12, 2026, on 3-11 shift. Between the dates of January 20, 2026, and April 21, 2026, the requirement to have a quarterly drill completed on each shift did not occur. 8/20/26 – A review of the documentation provided for the fire drill completed April 21, 2026, did not include the attendance of who participated in the drill. 8/20/26 – Findings were reviewed with E1 (ED) at approximately 3:55 PM. 8/20/26 – Findings were reviewed with E1 and E2 (HSD), E3 (BOM/HR) and E9 (RCD) at the exit conference beginning at approximately 4:00 PM.	Quarterly we will conduct quarterly fire drills as part of the state regulation. Our next quarterly fire drill will be conducted in October. Re-education was done by the ED on 8/24/2026 with the Maintenance Director on conducting fire drills and ensuring that attendance is taken. No residents were affected, and this will be monitored by the ED and the Maintenance Director or designee until 100% compliance is met.	

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3225.13.0 **3225.13.3** **S/S- E**	**Service Agreements** **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 and interviews, it was determined that for six (R1, R2, R5, R6, R7, and R8) out of six residents sampled for service agreement information, the facility failed to the list the residents' primary care physician's address on the service agreements. 1. 2/19/26 - R1 was admitted to the facility. The service agreement dated 3/26/26 lacked the primary care physician's address. 2. 5/25/22 - R2 was admitted to the facility. The service agreement dated 7/6/26 lacked the primary care physician's address. 3. 7/21/26 – R5 was admitted to the facility. The service agreement dated 8/19/26 lacked the primary care physician's address. 4. 3/28/24 – R6 was admitted to the facility. The service agreement dated 6/10/26 lacked the primary care physician's address. 5. 5/12/26 – R7 was admitted to the facility. The service agreement dated 5/12/26 lacked the primary care physician's address.	It was identified in resident R1, R2, R5, R6, and R7's service agreement that the physician's address was missing. We have since resolved the systematic change to include the physician's address in the service agreements. No residents were affected, and this will be monitored by the HSD and the ED or designee until 100% compliance is met.	9/10/2026

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	6. 11/26/21 – R8 was admitted to the facility. The service agreement dated 12/28/25 lacked the primary care physician's information. 8/20/26 2:30 PM – During an interview, E2 (HSD) confirmed the service agreements did not contain the physician's complete information, and she will contact IT to address issue. 8/20/26 3:51 PM - During an interview, E9 (RCD) confirmed the service agreements did not contain the physician's complete information, and she would notify the electronics vendor to have this corrected. 8/20/26 – Findings were reviewed with E1 (ED) and E2, E3 (BOM/HR) and E9 at the exit conference beginning at approximately 4:00 PM.		
3225.19.0 **3225.19.6** **3225.19.7** **3225.19.7.6** **S/S- D**	**Records and Reports** **Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.** **Reportable incidents include:** **Death of a resident in a facility or within 5 days of transfer to an acute care facility.** This requirement was not met as evidenced by:	It was identified that a death occurred within the facility and it was not reported by the 8-hour regulation for resident E10. Re-education was done by the Executive Director. No residents were affected, and this will be monitored by the HSD and the ED or designee until 100% compliance is met.	8/24/2026

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	Based on record review and the State Agency Incident Reporting System, it was determined that for one (R1) out of eight residents sampled for reportable incidents, the facility failed to timely report a death that occurred in the facility. 2/19/26 – R1 was admitted to the facility, was a DNR, and under hospice care. 4/26/26 6:59 AM – Per EMR entry, E10 (LPN) noted "during routine foley check, nurse observed that R1 was not breathing while the Oxygen concentrator was on." E10 noted that the "Hospice nurse pronounced R1 at 1:57 AM" on 4/26/26. 4/27/26 12:02 PM – Per State Agency Incident Reporting System, the facility reported the death, which was approximately 22 hours later. 8/20/26 – Findings were reviewed with E1 (ED) and E2 (HSD), E3 (BOM/HR) and E9 (RCD) at the exit conference beginning at approximately 4:00 PM.		

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