

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/15/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085036</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/08/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>FORWOOD MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1912 MARSH ROAD</b> <b>WILMINGTON, DE 19810</b>		
(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	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced complaint survey was conducted at this facility from March 5, 2019 through March 8, 2019. The deficiencies contained in this report are based on interviews, observations, review of resident's clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 40. The survey sample size was 2.</p> <p>Abbreviations/definitions used in this report are as follows:</p> <p>Abrasions-superficial wound caused by rubbing or scraping skin; CNA-Certified Nurse's Aide; Cervical collar - neck brace/device use to support a person's neck; C-spine - Cervical spine/bones of the neck, immediately below the skull; C-spine fracture - cervical neck fracture-bones of the neck are broken; DHCQ - Division of Health Care Quality/State agency that completes surveys in Long Term Care facilities; DON- Director of Nursing; Elopement - to run away or leave an area without staff knowledge; ER-Emergency Room; Hospice - a type of care and philosophy of care that focuses on the palliation of a chronically ill, terminally ill or seriously ill patient's pain and symptoms, and attending to their emotional and spiritual needs; NHA-Nursing Home Administrator; Odontoid fracture - the peg-like part of the second bone in the neck is broken; prn-as needed; Splenic hematoma - enlargement of the spleen</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

04/01/2019

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 (an organ in the upper far left part of the abdomen, to the left of the stomach) that can be caused by trauma; TAR - Treatment Administration Record; WanderGuard - bracelet worn by a resident on their wrist or ankle or attached to a assistive device, such as a wheelchair, that alerts staff with an audible alarm when the resident is near an alarmed door.	F 000			
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on closed record review, observation, interviews, review of the facility's policy and procedure, and other facility and hospital documents as indicated, it was determined that the facility failed to provide adequate supervision and an environment free of accident hazards as is possible for one (R1) out of two (2) sampled residents. R1 was able to propel his/herself in a wheelchair using his/her feet, from the Aspen Unit through a single lever door to the kitchen area. R1 was wearing a WanderGuard, which was to have locked down this single lever door and prevented him/her from exiting through it. After entering through the single lever door, R1 proceeded down a hall that led to the kitchen and to double doors, which opened via a push bar, and led to the outside loading dock. These double doors released from the inside and locked upon	F 689	1) Resident R1 does not reside in the community. When the incident occurred team members were assigned to monitor the door where the resident exited until the door alarm was verified to function properly. The magnet on the identified door was repaired on 2/19/2019. 2) Residents identified as an elopement risk have the potential to be affected by this practice. The Director of Engineering has conducted an audit of all egress doors in the Health Center for functionality of the Wander Guard and Stop Door (standalone door alarm) systems the morning after the incident. The door that R1 exited from was repaired by adjusting the ceiling censor the day after the incident and a mag-lock (combination	4/26/19	

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F 689	<p>Continued From page 2</p> <p>closing. R1 exited via the double doors outside onto the concrete loading dock, which had three (3) steps. R 1 fell to the ground off the loading dock and sustained injuries to the left eye, laceration and swelling to the lips and mouth, multiple abrasions to the arms and legs and a cervical neck fracture requiring evaluation and treatment at the hospital. The facility failed to ensure that R1 was adequately supervised and failed to ensure that the facility's WanderGuard system was functioning properly. This deficient practice resulted in harm to R1. Findings include:</p> <p>The Facility's Maintenance Policy and Procedure for Patient Wandering and Emergency Exit Alarm System (undated) stated, "Perform a weekly functional test of the Patient Wandering and Emergency Exit Alarm System...document each wing's test results separately...record results in the appropriate areas...Proceed to HealthCare entrance...pass through each door (includes Aspen Dining Room and Aspen exterior dock)...The alarms should sound and lights illuminate in that hall."</p> <p>Review of R1's clinical record revealed the following:</p> <p>2/22/16 - R1 was originally admitted to the facility.</p> <p>7/11/18 - R1 experienced a fall from the wheelchair with no injury. A care plan initiated for risk for falls due to impaired mobility and ambulation included the interventions: Alarm to bed/chair as ordered; Locomotion via w/c (wheelchair).</p> <p>1/23/19- A Nursing Fall Risk Evaluation stated that R1 remained a high risk for falls.</p>	F 689	<p>lock) was added to the door for increased security. All the door alarms are currently functioning properly. The NHA / designee conducted an audit 2/20/2019 to check functionality of wrist band transmitters on the residents wearing them to ensure they are functioning properly.</p> <p>DON/designee completed a chart audit on all residents that have been identified as elopement risks ensuring that the nursing Wander Guard Risk Evaluation and MDS assessments are consistent with the care plans.</p> <p>3) A root cause analysis was completed indicating that the wander guard for an egress door was not functioning properly and resident supervision was not adequate. The facility failed to identify a faulty alarm on a Wander Guarded door and did not follow company policy related to supervision for identified residents. The Director of Engineering / designee in-serviced the security and maintenance staff on the procedure related to the weekly audits for door security equipment. The 5p-12a security guard will test the wander guard system by using a resident wristband transmitter to ensure the alarm activates when the wristband transmitter is with two feet of a wander guarded door. The DON/designee in-serviced the professional staff related to residents with elopement risks determined by completing the Resident Risk Evaluation form for all new residents on the day of admission and residents that have a change of condition related to possible elopement risks. If it is determined the resident is at risk for wandering/elopement, a plan will be developed and implemented</p>		

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F 689	Continued From page 3  1/23/19 - A Nursing Wander Risk Evaluation stated that R1 scored 7, indicating that R1 was at risk of wandering (per 0-8 scoring).  1/25/19 - The quarterly MDS assessment stated that R1's daily decision making skills were severely impaired, that he/she did not ambulate and required extensive assist of one staff for transfers. R1 utilized a wheelchair for mobility and was self sufficient for locomotion around the unit.  1/29/19 at 11:39 PM - R1 was found sitting on the floor in front of his/her wheelchair in his/her room. R1 did not sustain any injury.  2/12/19 - The facility initiated a care plan for potential for elopement related to dementia. The care plan goal stated, "I will not leave the unit unassisted..." Interventions included: "apply wander guard if at risk for elopement; check wander guard placement daily and prn; monitor for signs and symptoms of wandering or attempts to leave the unit; redirect as needed; and involve activities to divert attention."  Review of the TAR revealed that R1's WanderGuard was checked for placement and functional on 2/18/19 on the 3-11 PM shift.  2/18/19 11:15 PM - A nursing progress note stated, "Resident s/p fall, sent to (hospital name) ER for evaluation." This note did not offer any further information such as to the extent of injuries, assessments and care provided, how the fall occurred, who was notified, and how and when R1 was sent to the hospital.  The facility's Incident Report revealed the following:	F 689	immediately and reviewed with nursing staff. The Care Plan includes: "Interventions to minimize the potential for Resident elopement "Notification to staff that the Resident is at risk "A current Resident photo will be located at the front reception desk (or indicated area) and in the medication book or electronic health record for staff/other reference "Resident Identification (ID) The frequency and responsibility for monitoring the Resident's location in the community/nursing unit are determined by the results of the Resident Risk Evaluation. This will be identified in the Care Plan. Policy and procedures have been reviewed and no revisions were necessary to achieve regulatory compliance. 4) The Security personal will conduct a weekly audit related to door alarms then report negative outcomes immediately to the NHA/Designee. The NHA/designee will immediately assign corrective action as appropriate and review all weekly audits. The DON/designee will conduct weekly audits of nursing Wander Guard Evaluations and MDS assessments for completion, interventions, and cohesiveness of resident care plans. Audit findings for both weekly audits will be reviewed during the QAPI meetings. Result thresholds are established at 100%. The frequency of audits will be determined by the QAPI committee as deemed appropriate.		

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F 689	<p>Continued From page 4</p> <p>Date of the Incident: 2/18/19; Time of Incident: 10:00 PM.</p> <p>Location: Outside of the building at the back entrance (employee entrance) bottom of steps. Unwitnessed fall, Resident (R1) got outside; wander guard alarm did not go off; Resident fell down steps of employee entrance. Part of Body injured: Trauma to left eye; Laceration and swelling to lips/mouth; multiple abrasions to arms/legs.</p> <p>2/19/19 - The facility's investigation report of the incident revealed the following: E4 (LPN) stated that at 9:10 PM E4 was about to enter the staff bathroom (located in the hall leading to the kitchen and loading dock), heard crying and a whimpering sound, checked the staff lunch room and realized the sound was coming from outside. Upon opening the double doors to the loading dock, E4 did not see anything, but heard the sounds more clearly. E4 walked out onto the concrete loading dock, which had 3 concrete steps located to the immediate right of the loading dock towards the sound and found R 1 on the ground by the loading dock. E4 yelled for help. E5 (RN) and E6 (CNA) responded. E5 did an assessment. E4, E5, and E6 together "supported R1's C-spine and rolled R1 onto a blanket and brought R1 back into the building," since the outside temperature was cold (35.6 degrees Fahrenheit).</p> <p>R1 was sent to the hospital ER for evaluation and was subsequently admitted to the hospital for further treatment. According to the hospital Discharge Summary Record, dated 2/27/19, R1 sustained a cervical neck fracture, a splenic hematoma, and an odontoid fracture. Neurosurgery was consulted and recommended non-operative conservative treatment with a</p>	F 689			

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F 689	<p>Continued From page 5</p> <p>cervical collar. R1 was transferred to the inpatient Hospice unit.</p> <p>2/26/19 - Review of the facility's investigation revealed a statement completed by E6 (CNA). The facility's investigation revealed that on the evening of 2/18/19, R1 was found by E6 attempting to exit the Aspen unit via double doors that lead into Independent Living. E6 had arrived at work at 7:00 PM when he/she observed R1 attempting to exit the Aspen unit. E6 "ran down, brought R1 back up, and informed the supervisor."</p> <p>3/6/19 - Observation revealed that the doors that R1 was attempting to exit through when found by E6 (CNA) on 2/18/19 at 7:00 PM are located at the end of the same hall, near the hairdresser's room, that leads to the kitchen and loading dock.</p> <p>3/6/19 at 1:45 PM - During a telephone interview with SP1 (DHCQ Special Investigator) and this surveyor, E5 (RN Supervisor) verified that he/she was the evening supervisor on 2/18/19. E5 stated that R1 is free to wander within the unit and did not need to be monitored. E5 stated that any time R1 went past any exit doors, they will alarm and staff would re-direct the resident. Additionally, E5 stated that R1 did not require 1:1 monitoring.</p> <p>Although R1 was actively exit seeking on the evening of 2/18/19, there was no evidence that the facility implemented any increased supervision of R1. Instead, the facility staff relied on the WanderGuard system alarms to alert staff of anyone attempting to exit. The WanderGuard system failed to work properly and R1 was able to exit onto the loading dock where he/she fell and sustained multiple injuries.</p>	F 689			

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F 689	<p>Continued From page 6</p> <p>3/8/19 at 11:20 AM - E1 (NHA) stated in an interview that "doors were replaced a few years ago, but appears the magnetic alarm contacts are not lining up on the door and frame." Review of the facility's Security Rounds documentation revealed that the last weekly testing of the WanderGuard alarm system, which included testing of all exit doors, was performed on 8/24/18. E1 stated that there had been a change in maintenance staff that performed the weekly security round and audit. According to E1, the new maintenance staff person had not been well trained by the previous maintenance staff before they left and consequently, did not perform the weekly testing and maintenance. Although the facility was checking R1's WanderGuard for functionality and placement, malfunction of the door sensors would cause the system to fail and not alarm. In addition, E1 also stated that E8 (Director of Maintenance) had no documented evidence that he/she was overseeing and/or supervising facility maintenance staff to ensure that procedures were being followed. E1 stated that E8 was on "administrative leave" as of 2/20/19. E1 stated that as of 2/20/19 the door sensors were repaired.</p> <p>The facility failed to complete weekly testing of the WanderGuard system according to facility policy to ensure the safety of residents who are wandering and/or exit seeking. This deficient practice resulted in harm to R1, who was able to exit onto the loading dock. R1 fell off the loading dock and sustained multiple injuries requiring hospitalization and Hospice care.</p> <p>Findings were reviewed and confirmed with E1 (NHA) and E2 (DON) at approximately 12:00 PM on 3/8/19.</p>	F 689			

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F 689	Continued From page 7 Interview and observation, by a surveyor and SP1, on 3/20/19 at 1:28 PM revealed that the sensor above the single lever door, through which R1 exited, has been repaired and now produces an alarm when a person wearing a WanderGuard comes into the area of the door. Additionally the facility installed a key pad next to this door for added security. On 3/20/19 at 2:50 PM the facility submitted their revised plan of correction to the State agency.	F 689			



**DELAWARE HEALTH AND SOCIAL SERVICES**

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

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



STATE SURVEY REPORT

NAME OF FACILITY: Forwood Manor

DATE SURVEY COMPLETED: March 8, 2019

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced complaint survey was conducted at this facility from March 5, 2019 through March 8, 2019. The deficiencies contained in this report are based on interviews, observations, review of resident's clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 40. The survey sample size was 2.</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></p> <p><b>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.</b></p> <p><b>This requirement is not met as evidenced by the following:</b> Cross Refer to the CMS 2567-L survey completed March 8, 2019: F689.</p>	<p>Cross Refer to CMS 2567-L survey completed March 8, 2019. Cross Refer attached POC dated 4/01/2019.</p>	

*[Handwritten signatures and dates]*  
Date 4/11/19