STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A015	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Exceptional Care for Children	11 Independence Way Newark, DE 19713

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, it was determined that for four (R13, R21, R24, and R27) out of twenty-two sampled residents, the facility failed to ensure enhanced barrier precautions (EBP) were followed. Findings include:According to the CDC (Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs, Updated July 12, 2022),Nursing home residents with wounds or indwelling medical devices, such as catheters, tracheostomies (breathing tubes), or feeding tubes, are more likely to get and carry these germs.Enhanced Barrier Precautions (EBP) are designed to reduce the spread of these germs.EBP includes the use of a gown and gloves when providing high contact care to these residents. High contact care includes dressing, bathing, transferring, providing hygiene, changing linens, device care, and wound care.Review of the facility's policy and procedure for Enhanced Barrier Precautions, last reviewed 1/26, revealed that . Enhanced Barrier Precautions are implemented for all Exceptional Care for Children residents due to existing indicators; currently all residents have at least one indicator. Staff are to wear gowns and gloves for all high contact resident care activities, which includes device care and use.1. Review of R13's record revealed:5/22/24 - R13 was care planned for EBP related to G tube (feeding tube) and tracheostomy (breathing tube). Interventions include Gowns/gloves will be worn by staff during close contact interventions. 05/12/26 1:08 PM - P1 (Medical Doctor), and E10 (RN) were observed in the community playroom evaluating R13. P1 and E10 were not wearing gowns while assessing R13's tracheostomy stoma, ears, and mouth. 5/12/26 2:21 PM - A progress note by E10 documented, .Trach (sic) stoma, mouth and ears assessed with drainage noted from L ear.2. Review of R24's record revealed: 5/22/24 - R24 was care planned for EBP related to G/J tube (feeding tube) and tracheostomy. Interventions include Gowns/gloves will be worn by staff during close contact interventions. 5/12/26 1:08 PM - P1 and E10 were observed in the community playroom evaluating R24. P1 and E10 were not wearing gowns while assessing R24's tracheostomy stoma, ears, and mouth. 5/12/26 2:34 PM - A progress note by E10 documented, .Trach stoma, mouth and ears assessed with no concerns.3. Review of R21's record revealed:5/22/24 - R21 was care planned for EBP related to G/J tube and tracheostomy. Interventions include Gowns/gloves will be worn by staff during close contact interventions. 5/12/26 1:15 PM - P2 (PA) was observed in the community playroom evaluating R21. P2 was not wearing gowns while assessing R21's tracheostomy stoma, ears, and mouth. 4. Review of R27's record revealed:5/22/24 - R27 was care planned for EBP related to G/J tube and tracheostomy. Interventions include Gowns/gloves will be worn by staff during close contact interventions. 5/14/26 approximately 2:45 pm - E9 (RN) was observed in the community playroom administering medications to R27 through the G/J-tube. E9 was not wearing a gown. 5/14/26 approximately 3:00 PM - Interview with E9 revealed that staff do not follow EBP when administering medications through feeding tubes while residents are in the common areas. 5/18/26 approximately 1:00 PM - An interview with E10 revealed that facility staff, including providers, do not follow EBP when rounding or caring for residents in the playroom. E10 stated that EBP is not something we have to do when the residents are cared for in the playroom.5/18/26 approximately 2:00 PM - During an interview, findings were reviewed and confirmed with E6 (RN, Clinical Support Services Manager).5/19/26 3:45 PM - Findings were reviewed with E1 and E3 during the exit conference.

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.

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, it was determined that for one (R41) out of one resident reviewed for resident rights, the facility failed to have evidence of notification to law enforcement after a controlled medication was not returned to the facility. Findings include:Review of R41's clinical record revealed:7/30/2024 - R41 was admitted to the facility with diagnoses including spastic quadriplegic cerebral palsy.1/23/26 - An order entered in R41's clinical record documented, diazepam - Schedule IV [controlled substance] tablet.Special instructions: Give every 6 hours as needed for increased spasticity, prior to transport.4/3/26 1:53 PM - A Nursing Progress Note documented, [FM1] arrived to pick up [R41] around 1230 [12:30 PM] for LOA [leave of absence].[R41] left the facility.with all necessary equipment, medications, and tube feeding.4/3/26 - A facility document entitled, Resident Leave of Absence Request and Agreement signed by FM1 documented, .Any unused medication must be returned to the facility upon the resident's return.Medication Name: diazepam Dose: 3 mg [milligrams] Quantity Dispensed: 2 doses.4/5/26 12:43 AM - A Nursing Progress Note entered by E11(RN) documented, [R41] returned to facility from LOA with [FM1].All equipment returned.[FM1] refused to return the doses [diazepam] and put the two unused doses of diazepam back into her personal bag.Doses [diazepam] marked under missing supplies on LOA paperwork, on-call administrative team and DON notified via email.4/5/26 3:00 AM - A facility document entitled, Patient Incident Report was completed and signed by E11 documented, .[R41] returned from LOA at 2355 [11:55 PM] instead of 2100 [9:00 PM].[FM1] asked this nurse [E11] what is done with unused diazepam doses. [E11] stated that we have to properly dispose of them.[FM1] then put the diazepam (2 unused doses) back into her personal bag and stated, ?Well then I'm taking these back home to save for next time if you're just going to throw them out.'.admin [Administrator] on-call notified via email.4/15/26 1:29 PM - A Nursing Progress Note entered by E12 (ADON, LPN) documented, On 4/6 [4/6/26] it was reported that [R41] returned from LOA with [FM1] and that [R41]'s 2 doses of prn (sic) [as needed] valium [diazepam] were unused.This nurse [E12] and DON have attempted to call [FM1] by phone since 4/7 [4/7/26]. On this day, this nurse texted [FM1] at 1049 [10:49 AM] requesting she call this nurse.4/20/26 1:11 PM - A Nursing Progress Note entered by E12 documented, This nurse [E12] spoke with [FM1] regarding the 2 doses of prn (sic) [as needed] valium [diazepam] that was kept by guardian after last LOA. [FM1] informed that she cannot keep any unused narcotics that [facility] must dispose of them properly and keep proper records.5/4/26 10:25 AM - A Nursing Progress Note entered in R41's clinical record documented, [FM1] returned narcotics from [R41]'s recent LOA. Medication was wasted by two nurses per policy.5/19/26 10:00 AM - During an interview, E1 (NHA) stated, I don't have any knowledge of any police reports or of law enforcement being contacted. I was on leave when this incident occurred. [E2, NHA] was the on-call Administrator at the time.5/19/26 10:15 AM - During an interview, the surveyor asked E3 (DON) if law enforcement was notified when FM1 refused to return the diazepam medication. E3 stated, The police were not notified. We updated the LOA policy for drug diversion after this incident to notify law enforcement. The surveyor asked E3 when law enforcement would be notified if a guardian does not return a controlled substance as agreed to the facility upon return from LOA, because it was not stated in the policy. E3 stated, Law enforcement would be contacted because we don't want our nurses to get into an altercation or put themselves in danger.5/19/26 10:30 AM - During an interview, E12 stated, It was hard to get in contact with [FM1] to return the medication. The surveyor asked E12 when law enforcement would be notified if a parent or guardian does not return medication to the facility after LOA. E12 stated, I don't know when the police would be contacted.5/19/26 1:50 PM - During a telephone interview, E11 stated, .I was taken aback when [FM1] would not return the diazepam. The surveyor asked who you informed that FM1 refused to return the diazepam doses? E11 stated, I emailed the Nurse Administrator On-Call [E7], the Administrator On-Call [E2], and the DON (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[E3]. The surveyor asked E11 if she was aware of the updated LOA policy on drug diversion. E11 stated, I believe we report it to the Administrator and the Education Team. The surveyor asked E11 if law enforcement would be contacted if medication is not returned to the facility when a resident comes back to the facility from LOA. E11 stated, The LOA policy was changed for preventive education. I don't know if law enforcement was a route going to be taken.5/19/26 2:00 PM - Findings were reviewed with E1.5/19/26 3:45 PM - Findings were reviewed with E1 and E3 during the exit conference.