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

PRINTED: 03/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	08A015		12/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEPTIONAL CARE FOR CHILDREN	11 INDEPENDENCE WAY NEWARK, DE 19713

(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	INITIAL COMMENTS Revised Report following IRD request for Tag F322. F322 removed. An unannounced annual survey was conducted at this facility from December 13, 2011 through December 19, 2011. The deficiencies contained in this report are based on observations, interviews, record reviews and review of other documentation as indicated. The facility census the first day of the survey was 22 (twenty-two). The survey sample totaled 10 (ten) residents, which included 9 (nine) active records and 1 (one) closed record.	F 000	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance. The deficiencies cited have been or will be corrected by the dates indicated.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the	F 225	F225 1. Resident 1 reveals no further complications related to the incident. 2. Resident 1 and all residents at risk for fracture are assessed every 12 hours to determine deviation from baseline. Changes in condition are communicated to attending physician for any directed change in course of treatment.	3/16/12

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

Administrator — 03/13/2012

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 225	Continued From page 1 State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and review of facility documents, it was determined that the facility failed to ensure that an injury of unknown origin for one (1) resident (R1) out of 10 sampled was thoroughly investigated. Findings include: R1's Progress Notes included a nurse's note, dated 8/17/11 and timed 5:06 PM, that stated, "1530 (3:30 PM) - This nurse was notified by the nursing assistant that (name/R1) right upper thigh looked bigger than the left. Upon assessment, the right thigh is swollen and firm, warm to touch. Right thigh circumference measuring 20.5 inches. Left thigh measuring 19 3/8 inches... does not appear to be in pain. Smiles when spoken to Dr. (name) ordered for him to be sent to ...ER (Emergency Room) for evaluation... "	F 225	3. All Incidents and Accidents will be reported to the Compliance Manager, DON and NHA within the same tour of duty as the incident/accident is noted. Statements will be obtained and interviews conducted with all caregivers or staff involved in the incident. Incidents/Accidents noted to have in injury of unknown origin will result in statements from all caregivers and staff that interacted with the resident as well as interviews for the period to be identified as 24 hours prior to the incident/accident. All findings will be reviewed to determine causation and plan of care alterations. Reportable Incidents/Accidents will continue to be relayed to DLTCRP timely and again within 5 days for follow-up. All staff will be in-serviced regarding above.	

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F 225	Continued From page 2 The facility's "Incident Report Form" and investigation, dated 8/17/11 was reviewed. E3's (nurse) witness statement, dated 8/17/11, stated "... right upper leg swollen, firm, warm to the touch. Right upper leg larger then (sic) the left." The incident report listed the only Witness(es)/Involved Persons as E3 despite the nurse's note that stated she was notified by a nursing assistant. During an interview on12/16/11 at 3:10 PM, E4 (CNA who accompanied R1 to the ER) stated that she had accompanied R1 to the ER but, had not been the CNA assigned to R1 on 8/17/11. The facility's records revealed that E5 (CNA) was assigned to R1 that day. During an interview on 12/19/11 at 11:45 AM, E5 stated that she was performing R1's morning care, when she noticed that his right leg appeared to be swollen and felt warm and noticed that one pant leg was tighter than the other side, which was loose. E5 stated she notified the nurse (E3). E3 and E6 (Director of Education) assessed R1. E5 stated that she was questioned by E6 and gave a verbal account to the nurses but denied completing any statements for the facility's investigation or being asked to write a statement regarding this incident by any staff. During an interview on 12/19/11 at 12:15 PM, E2 (Director of Nursing) stated that she had viewed the facility's surveillance/video tape with E7 (Compliance Manager), who interviewed the nurse(E3) and did the investigation. E2 recalled that a CNA noticed a small red/pinkish mark on R1's right groin, the doctor was notified and R1 was sent to the ER. E2 stated that R1 was being	F 225	4. The DON and NHA will review all Incident/Accident Reports upon initial notification to Compliance Manager and to ensure thorough investigation, Abuse Prohibition Protocol and effective changes in the plan of care and/or policy/procedure to prevent reoccurrence. The Medical Director will review completed Incidents/ Accident Reports. All Incident/Accident Reports will be tracked/trended and reported to the QA Committee for further recommendation.	

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F 225	Continued From page 3 treated for low bone density at that time and was known to have a history of fractures. On 12/19/11 at 12:30 PM, an interview was conducted with E7, E1 (Administrator) and E2. Initially, E7 incorrectly identified E4 as the CNA who reported R1's condition to E3 as she reviewed the incident report. E7 was informed by the surveyor that during interviews, it was discovered that E4 was the CNA who accompanied R1 to the ER and that E5 was the CNA who reported the incident. E2 reminded E7 that they had reviewed the video tape together. E7 was asked by the surveyor what she usually does as part of the investigation. E7 stated that she would gather documentation from the CNAs, nurses, anyone present, review the resident's history and view video tapes from the facility's surveillance cameras. E7 stated that she remembered viewing the video tape but failed to document that as part of the investigation. E7 acknowledged that statements/interviews were not obtained from all staff that had been involved in R1's care preceding the event. E1, E2, and E7 acknowledged that the facility failed to complete a thorough investigation.	F 225		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323 1. Resident 8 revealed no further complications related to the incident. Resident 8's crib was reviewed and revealed no mechanical defect. All medication carts remain locked when not in use. Supply Room #127 and Respiratory Supply Room #222 remained locked when not occupied by staff.	3/16/12

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F 323	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews and review of other facility documentation, it was determined that the facility failed to ensure that the resident's environment remained as free of accident hazards as is possible. The facility failed to ensure that wheels on a crib were locked before transferring one (R8) out of ten (10) sampled residents from a wheelchair to the crib which resulted in a fall without injury. Additionally, the facility failed to ensure that medication carts were locked and that chemicals were secured in a locked room. Findings include: Review of the facility's policy, dated 03/09 and entitled, "Transferring the Resident" stated, "...To prevent accidents or injuries, the wheels of the bed, stretcher and/or wheelchair must always be locked when transferring a resident... Enlist the help of others to assist with the transfer..." 1. R8 was admitted to the facility on 9/21/10. R8's diagnoses included having a tracheostomy and ventilator dependent, developmental delay, epilepsy and a gastrostomy tube (tube directly into stomach for feeding). The Annual MDS (Minimum Data Set) assessment, dated 9/25/11, revealed that R8 was coded as having one (1) fall without injury since the prior assessment. R8's care plan, dated 9/11/08 and entitled, "Safety - at risk for falls Diagnosis... Developmental delay..." listed interventions that	F 323	2. All resident beds and cribs have been reviewed to ensure that locking mechanisms were in working order. All Supply Rooms and Respiratory Supply Rooms remain locked when not occupied by staff. All medication carts have been checked to ensure that locks are in working order. 3. All caregivers and ancillary staff that are trained to assist with resident transfers or emergency services will be in-serviced to ensure that prior to transfer and again prior to exit from an occupied resident room, crib and bed wheels are in the required locked position. Licensed Nursing Staff will be in-serviced to ensure that the medication carts that are not in use remain locked. Supply Room #127 and Respiratory Room #222 will be equipped with a security card access (coded to those personnel deemed appropriate to access) so that the doors will be remain lock but will not impede access in the case of a medical emergency as these areas store life saving equipment and supplies.	

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F 323	Continued From page 5 included, "... Child assessed at risk for falls, Crib rails to be raised & (and) locked when child is in crib... Requires crib canopy... Lock wheels on any transport device when stationary,..." R8's care plan, dated 10/4/10 and entitled, "Mobility - d/t (due to) decreased mobility r/t (related to) weakness, dependent on staff for mobilization, learning to be more mobile... Diagnosis... Developmental delay..." listed interventions that included, "... Non-ambulatory - crawls around in bed and during floor play..." Review of R8's incident report of a witnessed fall, dated 9/11/11 and timed 8:30 PM stated, "This nurse (E9) called to room by CNA (name/E10), she explained that (name/R8) had fallen out of the bed and hit the floor, unsure of what hit the floor, pts (patient) arm/side or pts head. She explained that she and assisting CNA (name/E11) were trying to secure crib and pt pushed up and over the side. Full assessment done by this nurse, pt awake and alert, crying and pushing staff away, pt moving all extremities per baseline. Pt attempting to watch TV per baseline. VSS (Vital Signs Stable)." The on-call physician was notified and ordered to wake R8 every hour overnight to assess Neuro (neurological) status and call if baseline changed. E10's witness statement, dated 9/11/11 stated, "...While transferring... in the bed, ...immediately noticed... crib wasn't locked in place, causing it to move. After placing him in the crib safely, I pulled the crib back off the closet wall enough for (name/E11) to get to the other side and help me with ...care.... I tried to hurry and lock the wheel of the bed. I had one hand on (R8), but as the bed	F 323	4. Maintenance Staff will maintain a monthly log for crib/bed checks to ensure proper working order, including locks, is maintained. Corrections will be made immediately upon discovery and a report made to Director of Facilities. The Log will be reviewed by Director of Facility and NHA monthly. Random audits will be conducted by RN Staff Educator, ADON, or designee to ensure medication carts remained locked when not in use by a licensed nurse. Random audits will be conducted of occupied beds to ensure wheels are locked appropriately. Immediate corrective action will take place including progressive disciplinary action. Audits will be Tracked/Trended and reported to QA Committee for further recommendation. All supply areas that stock items that can be harmful to residents will be equipped with a security card access system (as locking would create unnecessary delay in the case of a medical emergency as these areas stock life saving equipment and supplies) or a self closing door with classroom-style lock.	

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F 323	Continued From page 6 started moving I was trying to stop it and at that point took my hand off of (R8). I didn't realize that (E11) was on the back side of the crib trying to lock the back wheel to help me stabilize the crib as oppose (sic) to having a hold on (R8). This was my miss communication (sic). ... heard E11 scream...saw (R8) falling to the floor..." E11 stayed with R8 while E10 went to notify the nurse. E9 (nurse) and E12 (Charge nurse) came and assessed R8. E9 notified the physician on call. Review of E11's witness statement, dated 9/11/11 stated that as each CNA was checking/locking the wheels on the crib, "...we both took our eyes off of (R8). In that moment, he fell completely out..." During an interview on 12/19/11 at 2:00 PM, E7 (Compliance Manager) acknowledged the findings. She stated that it is expected that staff would ensure that wheel locks and crib side rail latches were secured. E7 stated that one person should have had their hand on R8. She denied any mechanical problems with equipment (ie. wheels or locks) but believed this accident occurred due to miscommunication between the CNAs. E7 stated that she spoke with both E10 and E11 and did an informal in service which included different scenarios, regarding what could have been done to prevent this accident and any reoccurrence. This was also reflected in the "Reviewer notes/Plan of Correction" portion of the incident report. The facility failed to follow the facility policy and R8's plan of care to safely transfer R8 from his wheelchair to his crib. 2. On 12/14/11 at 9:45 AM, the second floor medication cart was observed unattended and	F 323		

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F 323	Continued From page 7 unlocked in the hall. E13 (nurse) acknowledged the cart should be locked. 3. During a medication pass observation on 12/15/11 at 10:00 AM, E14 (nurse) failed to lock the medication cart after she returned an eye ointment to the cart. E14 walked away from the med cart and headed toward another room down the hall. When asked by the surveyor if the cart should be locked, E14 acknowledged that it should and proceeded to do so. 4. On 12/16/11 at 8:20 AM, E3 (nurse) finished administering medications to a resident. E3 walked away from the med cart and headed toward another room down the hall. When asked by the surveyor if the cart should be locked, E3 acknowledged that it should and proceeded to do so. 5. On 12/19/11 at 12:00 PM, the first floor medication cart was observed unattended and unlocked in the hall. Several maintenance workers were observed nearby in the dining room. E3 came out of a resident room at the far end of the hall and headed toward the medication cart. She acknowledged the finding and stated that she forgot to lock it and was attending to alarms. 6. Observation on 12/13/11 during the initial tour with E2 (Director of Nursing) of the second floor revealed an unattended, unlocked medication cart with the medication keys left in the lock. E2 acknowledged the finding. 7. Observation on 12/16/11 at 8:45 AM revealed	F 323		

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F 323	Continued From page 8 that the respiratory supply room #127 was unlocked and accessible to residents and contained the following: Bacitracin (5), 1 oz, "For external use only," Listermint (4), 3 oz, "Do not swallow, Keep out of reach of children," Sunscreen (4), 3 oz, "For external use only," Epi-Clenz (2) 16 oz, "For external use only," Hydrogen Peroxide (4) 4 oz, "For external use only," Syringes. An interview with E8 (Director of Facilities) confirmed that the door was unlocked. 8. Observation on 12/16/11 at 9:30 AM revealed that Respiratory Supply room #222 was unlocked and accessible to residents and contained the following: Listermint (5) 3 oz, "Do not swallow, Keep out of reach of children," Oral Balance (5), 1.5 oz, Keep out of reach of children, Hydrogen Peroxide (6), 4 oz, "For external use only," Hydrogen Peroxide (1), 16 oz, "For external use only," Curad Vitamin A & D ointment (4), 2 oz, "Keep out of reach of children," Sooth & Cool moisturizing, (7), 8 oz, For external use only, Epi-clenz (3) 16 oz, "For external use only," Syringes. Findings were reviewed with E1 (Administrator), E2 (DON) and E7 (Compliance Manager) during the exit conference. E2 stated that the children were never unsupervised.	F 323		

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

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Exceptional Care for Children

DATE SURVEY COMPLETED: December 19, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Post IDR Report **The State Report incorporates by reference and also cites the findings specified in the Federal Report.** An unannounced annual survey was conducted at this facility from December 13, 2011 through December 19, 2011. The deficiencies contained in this report are based on observations, interviews and review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was 22. The survey sample totaled 10 residents.	F225 3/16/12 1. Resident 1 reveals no further complications related to the incident. 2. Resident 1 and all residents at risk for fracture are assessed every 12 hours to determine deviation from baseline. Changes in condition are communicated to attending physician for any directed change in course of treatment. 3. All Incidents and Accidents will be reported to the Compliance Manager, DON and NHA within the same tour of duty as the incident/accident is noted. Statements will be obtained and interviews conducted with all caregivers or staff involved in the incident. Incidents/Accidents noted to have in injury of unknown origin will result in statements from all caregivers and staff that interacted with the resident as well as interviews for the period to be identified as 24 hours prior to the incident/accident. All findings will be reviewed to determine causation and plan of care alterations. Reportable Incidents/Accidents will continue to be relayed to DLTCRP timely and again within 5 days for follow-up. All staff will be in-serviced regarding above. 4. The DON and NHA will review all Incident/Accident Reports upon initial notification to Compliance Manager and to ensure thorough investigation, Abuse Prohibition Protocol and effective changes in the plan of care and/or policy/procedure to prevent reoccurrence. The Medical Director will review completed Incidents/ Accident Reports. All Incident/Accident Reports will be tracked/trended and reported to the QA Committee for further recommendation.
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**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:**	F323 3/16/12 1. Resident 8 revealed no further complications related to the incident. Resident 8's crib was reviewed and revealed no mechanical defect. All medication carts remain locked when not in use.

Provider's Signature [signature] Title Administrator Date 3/13/2012

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

DHSS - DLTCRP
3 Mill Road, Suite 308
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STATE SURVEY REPORT

NAME OF FACILITY: Exceptional Care for Children

DATE SURVEY COMPLETED: December 19, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Cross refer to the CMS 2567-L survey report date completed 12/19/11, F225 and F323.	Supply Room #127 and Respiratory Supply Room #222 remained locked when not occupied by staff. 2. All resident beds and cribs have been reviewed to ensure that locking mechanisms were in working order. All Supply Rooms and Respiratory Supply Rooms remain locked when not occupied by staff. All medication carts have been checked to ensure that locks are in working order. 3. All caregivers and ancillary staff that are trained to assist with resident transfers or emergency services will be in-serviced to ensure that prior to transfer and again prior to exit from an occupied resident room, crib and bed wheels are in the required locked position. Licensed Nursing Staff will be in-serviced to ensure that the medication carts that are not in use remain locked. Supply Room #127 and Respiratory Room #222 will be equipped with a security card access (coded to those personnel deemed appropriate to access) so that the doors will be remain lock but will not impede access in the case of a medical emergency as these areas store life saving equipment and supplies. 4. Maintenance Staff will maintain a monthly log for crib/bed checks to ensure proper working order, including locks, is maintained. Corrections will be made immediately upon discovery and a report made to Director of Facilities. The Log will be reviewed by Director of Facility and NHA monthly. Random audits will be conducted by RN Staff Educator, ADON, or designee to ensure medication carts remained locked when not in use by a licensed nurse. Random audits will be conducted of occupied beds to ensure wheels are locked appropriately. Immediate corrective action will take place including progressive disciplinary action. Audits will be Tracked/Trended and reported to QA Committee for further recommendation. All supply areas that stock items that can be harmful to residents will be equipped with a security card access system (as locking would create unnecessary delay in the case of a medical emergency as these areas stock life saving equipment and supplies) or a self closing door with classroom-style lock.