

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

PRINTED: 05/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08A016	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2015
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL CARE FOR CHILDREN		STREET ADDRESS, CITY, STATE, ZIP CODE 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

F 000

An unannounced annual survey was conducted at this facility from April 28, 2015 through May 7, 2015. The deficiency contained in this report is based on observation, review of facility documents as indicated and interview. The facility census the first day of the survey was 32. The Phase 1 sample included review of 6 active residents' records and Phase 2 included review of 4 residents; 3 active and 1 closed record.

Abbreviations used in this report are as follows:
NHA - Nursing Home Administrator;
DON - Director of Nursing;
RN - Registered Nurse.

F 441 483.85 INFECTION CONTROL, PREVENT SS=D SPREAD, LINENS

F 441

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

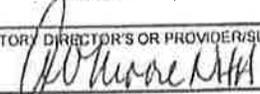
(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must

The statements made on this Plan of Correction are not an admission to and does not constitute an agreement with the alleged deficiencies herein. The plan of Correction is prepared and/or executed solely because it is required by the provisions of both state and federal law.

F441

1. E3 has been in-serviced regarding tablet/capsule administration technique of medication as well as handwashing
2. All licensed nurses have attended semi-Annual Skills Fair as scheduled May 10, 2015 through May 16, 2015 had have completed competency testing of administration technique for tablets and capsules via return demonstration. Additionally, all nursing staff have completed competency through return demonstration for Hand Washing Technique as defined by the World Health Organization.

6/1/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 5/19/2015
--------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------	-------------------------------

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.

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

PRINTED: 05/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08A015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2015
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL CARE FOR CHILDREN		STREET ADDRESS, CITY, STATE, ZIP CODE 11 INDEPENDENCE WAY NEWARK, DE 18713	
(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 441	<p>Continued From page 1</p> <ul style="list-style-type: none"> isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations during the medication pass, facility documents and interview, it was determined that the facility failed to maintain an Infection Control Program designed to provide a safe and sanitary environment and to help prevent the development and transmission of disease and infection related to handwashing and medication administration for one (R2) resident out of a total of 10 sampled. Findings include:</p> <p>1. During the medication pass with E3 (RN) on 5/6/15 from approximately 1:50 PM to 2:05 PM, the following observations were made:</p> <ul style="list-style-type: none"> a. For R2, E3 popped pills for 2 different medications directly from the bubble pack in which the medications were stored into his hand and then placed the medications into a paper souffle cup. 	F 441	<ul style="list-style-type: none"> 3. The RN Staff and Family Educator (Staff Development) and /or designee will complete weekly audits of both Medication Administration for tablets/capsules (licensed staff) and Handwashing Technique (all staff) with the following schedule. <ul style="list-style-type: none"> a. 3 per day for one week or until 100% compliance is achieved. b. 3 per week for one month or until 100% compliance is achieved. 4. The DON will review the logs for completion and compliance, determining the need for any adjustments in the schedule of audits. Findings will be reported to the QA Committee for further recommendation.

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

PRINTED: 05/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08A016	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2015
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL CARE FOR CHILDREN		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
F 441	<p>Continued From page 2</p> <p>b. For R2, E3 was observed washing his hands and then contaminating his clean hands by using his bare hands to turn off the faucet.</p> <p>Findings were reviewed and confirmed with E3 during an interview on 5/8/15 at approximately 2:06 PM Immediately after the medication pass. E3 stated he worked per diem (temporary) in the facility for many years prior to recently changing to full-time status and he did not always have the same resident assignments.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) during an interview on 5/7/15 at approximately 12 PM. At approximately 2 PM. E1 and E2 stated the facility has an upcoming skills fair, including the proper transfer of medications from bubble packets to medication cups and for hand washing with return demonstrations by nursing staff.</p> <p>Documents provided by the facility for use in the upcoming skills fair were reviewed. Shared Governance Meeting notes, dated 4/7/15, stated, "... Skills Fair Updates... We have the bubble packets from (name of pharmacy) for proper transfer to med (medication) cup... Hand washing...". The World Health Organization procedure, unable to read date, entitled "How to Handwash?", being used by the facility for the skills fair, stated, "... Dry hands thoroughly with a single use towel; Use towel to turn off faucet; Your hands are now safe...".</p>	F 441	



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-8661

STATE SURVEY REPORT

NAME OF FACILITY: Exceptional Care for Children

DATE SURVEY COMPLETED: May 7, 2015

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>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual survey was conducted at this facility from April 28, 2015 through May 7, 2015. The deficiency contained in this report is based on observation, review of facility documents as indicated and interview. The facility census the first day of the survey was 32. The Phase 1 sample included review of 6 active residents' records and Phase 2 included review of 4 residents; 3 active and 1 closed record.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>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.</p>	<p>The statements made on this Plan of Correction are not an admission to and does not constitute an agreement with the alleged deficiencies herein. The plan of Correction is prepared and/or executed solely because it is required by the provisions of both state and federal law.</p> <p>F441</p> <ol style="list-style-type: none"> E3 has been in-serviced regarding tablet/capsule administration technique of medication as well as handwashing All licensed nurses have attended semi-Annual Skills Fair as scheduled May 10, 2015 through May 16, 2015 had have completed competency testing of administration technique for tablets and capsules via return demonstration. Additionally, all nursing staff have completed competency through return demonstration for Hand Washing Technique as defined by the World Health Organization. 	<p>6/1/2015</p>

Provider's Signature Whitney NHA Title Administrator Date 5/19/2015



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: May 7, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>This requirement is not met as evidenced by: Cross refer to CMS 2567-L survey exit date 5/7/15, F441.</p>	<ol style="list-style-type: none"> 3. The RN Staff and Family Educator (Staff Development) and /or designee will complete weekly audits of both Medication Administration for tablets/capsules (licensed staff) and Handwashing Technique (all staff) with the following schedule. <ol style="list-style-type: none"> a. 3 per day for one week or until 100% compliance is achieved. b. 3 per week for one month or until 100% compliance is achieved. 4. The DON will review the logs for completion and compliance, determining the need for any adjustments in the schedule of audits. Findings will be reported to the QA Committee for further recommendation. 	

Provider's Signature *[Signature]* Title Administrator Date 5/19/2015