DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: The Mary Campbell Center

DATE SURVEY COMPLETED: February 2, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal report. An unannounced Annual, Emergency Preparedness and Complaint Survey was conducted at the above-named ICF/IID facility from 1/27/26 to 2/2/26. The facility census was sixty-eight (68) on the first day of the survey. The survey sample size was fourteen (14) residents. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements.** **This requirement is not met as evidenced by:** Cross reference to the CMS 2567-L survey report completed on February 2, 2026: W102, W104, W111, W120, W158, W159, W160, W195, W196, W198, W224, W225, W318, W320, W321, and W322.		
3201.9.0	**Records**		

Provider's Signature Tarah Pappas Title Executive Director Date 03/09/2026

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3201.9.1	**Accuracy of records: There shall be a separate clinical record maintained on each resident as a chronological history of the resident's stay in the nursing facility. Each resident's record shall contain current and accurate information including the following:** Based on interview and record review for two (C1 and C12) out of six reviewed for infection control, the facility failed to maintain accurate records for vaccines. Findings included: 1. Review of C1's clinical record revealed: 8/16/09 - C1 was admitted to the facility with following diagnoses: profound intellectual disability, chromosomal abnormalities, and generalized idiopathic epilepsy. 9/28/19 - A standing physician's order documented that C1 was to receive the pneumococcal vaccine per CDC recommendation and last dose received 12/6/17. 3/21/19 – A review of C1's immunization electronic record documented that C1 received the Pneumococcal 23 vaccine on the aforementioned date. 2/2/26 11:01 AM – During an interview, E33 (IP) confirmed that latest pneumococcal data for C1 was not accurate in the standing order and that did not match the date on the immunization record.	*3201.9.1 – Accuracy of records: There shall be a separate clinical record maintained on each resident as a chronological history of the resident's stay in the nursing facility. Each resident's record shall contain current and accurate information including the following:* *1. Accurate records for vaccines* **Section A – Individual(s) impacted.** The facility failed to document accurate Pneumococcal 23 vaccine administration dates in the Electronic Medical Records (EMRs) for residents C1 and C12. The Infection Preventionist revised C1's EMR to reflect the correct administration date for the Pneumococcal 23 vaccine. Resident C12 was discharged from the facility on 2/5/2026. **Section B – Identification of Other Residents with the potential to be affected by the deficient practice.** All residents have the potential to be affected by the deficient practice. The Infection Preventionist or designee will audit all residents' EMRs to identify and correct inaccurate Pneumococcal 23 Vaccine administration dates. **Section C – System Changes** Resident vaccine orders will be revised to reflect the following: Physician orders for vaccines will be entered as General orders to alert staff to administer vaccines in accordance with CDC guidance. (i.e., "Pneumococcal Vaccine per CDC guidelines.") At the time vaccines are administered, the vaccine, dose, route, administration site, vaccine lot number, and expiration date will be documented in the Preventive Health section of resident's EMR.	

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	2. Review of C12's clinical record revealed: 4/12/07 - C12 was admitted to the facility with the following diagnoses: profound intellectual disability and seizure disorder. 12/10/24 - A standing physician's order documented that C12 was to receive the pneumococcal vaccine per CDC recommendation and last dose received 12/6/17. 2/2/26 11:01 AM – During an interview, E33 (IP) confirmed that latest pneumococcal data for C12 was not accurate in the standing order and that did not match the date on the immunization record. The facility failed to maintain current and accurate data in C1 and C12's clinical record. 2/2/26 4:00 PM - Findings were discussed with E1 (ED) and E2 (DON) during the exit conference.	The Pneumococcal Vaccine Policy has been revised to include documentation in the Preventive Health section of the EMR (Attachment A). The Staff Educator or designee will train licensed nursing staff on the revised policy. **Section D – Success Evaluation** The Infection Preventionist or designee will audit residents' EMRs weekly to identify residents who are not in compliance with the vaccine administration policy. Once audit results are 100% correct for four consecutive weeks, the Infection Preventionist or designee will conduct monthly audits until 100% accuracy is attained for three consecutive months. Once monthly audit results are 100% correct, the Infection Preventionist or designee will conduct quarterly audits until 100% compliance is achieved for two consecutive quarters. Audits will be conducted annually thereafter. Audit results will be reviewed quarterly at Quality Assessment and Assurance Committee meetings. (Attachment B)	**03/19/2026**
Title 16: Delaware Code § 1132. Reporting requirements.	**(a) (1) Any employee of a facility or person who provides services to a patient or resident on a regular or intermittent basis who has reasonable cause to believe that a patient or resident in a facility has been abused, neglected, mistreated, or financially exploited or has been the victim of medication diversion shall immediately report the abuse, neglect, mistreatment, financial exploitation, or medication diversion to the Department by oral communication. The employee or person providing services**	**Title 16 1132 reporting requirements** **Section A – Individual(s) impacted.** The resident involved (C13) was interviewed immediately after the Mary Campbell Center was notified about the incident. The staff member (E35) was then suspended and, as a result of the investigation, was terminated from MCC employment. Staff who witnessed the incident failed to follow the MCC "Prevention of Abuse, Neglect, and Exploitation,	

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	to a patient or resident shall file a written report within 48 hours after the employee or person providing services to a patient or resident first gains knowledge of the abuse, neglect, mistreatment, financial exploitation, or medication diversion. Based on interview and record review for one (C13) out of five residents reviewed for allegations of abuse, the facility failed to report the allegation immediately. Findings include: Review of C13's clinical record revealed: 11/3/24 – C13 was admitted to the facility. 8/19/25 11:00 AM – A facility reported incident documented that E35 (RCT) forcibly placed their hand over C13's mouth. 8/22/25 7:07 PM – A report was submitted to the State Agency by the facility. 1/29/26 12:10 PM – During an interview, E15 (Policy RN) confirmed that the facility submitted the report to the State Agency 76 hours after the incident occurred. 2/2/26 4:00 PM – Findings were discussed with E1 (ED) and E2 (DON) during the exit conference.	Investigation and Reporting of Alleged Incidents, and Corrective Actions" policy and procedure. (Attachment C) **Section B – Identification of Other Residents with the potential to be affected by the deficient practice.** All residents have the potential to be affected by the deficient practice. **Section C – System Changes** The Staff Educator provided "Prevention of Abuse, Neglect, and Exploitation, Investigation and Reporting of Alleged Incidents, and Corrective Actions" policy training in February for MCC staff, consultants, and contract partners. (Attachment D – Skills Fair training documents) The Staff Educator or designee will coordinate quarterly mandatory training for MCC staff, consultants and contract partner on "Prevention of Abuse, Neglect, and Exploitation, Investigation, and Reporting of Alleged Incidents and Corrective Actions" policy and procedure with the first training sessions to occur on or before March 19, 2026. The State of Delaware Department of Justice will provide training on Abuse, Neglect, and Exploitation in 2027. Representatives from the Department of Justice provided staff training in November 2025. The next available dates were in 2027. (Attachment E) **Section D – Success Evaluation** The Director of Nursing (DON) or designee will audit incidents reported to the Division of Health Care Quality since February 1, 2026 to determine if	

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		the Center complies with the "Prevention of Abuse, Neglect, and Exploitation, Investigation, and Reporting of Alleged Incidents and Corrective Actions" policy. (Attachment F) The DON or designee will conduct weekly audits of DHCQ reportable incidents to assess compliance with ANE reporting requirements until 100% success is reached for four consecutive weeks. Then, the DON or designee will conduct monthly audits of DHCQ reportable incidents to ensure compliance with ANE reporting requirements until compliance reaches 100% success for four consecutive months. Once success is achieved for four consecutive months, the DON or designee will conduct quarterly audits of DHCQ reportable incidents until compliance reaches 100% success for four consecutive quarters. Audit results will be discussed at quarterly Quality Assessment and Assurance Committee meetings.	03/19/2026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G013	A. BUILDING _____ B. WING _____	C 02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY CAMPBELL CENTER	4641 WELDIN RD WILMINGTON, DE 19803

(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
E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from January 27, 2026 through February 2, 2026. The facility census was 68 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
W 000	INITIAL COMMENTS An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from January 27, 2026 through February 2, 2026. The deficiencies contained in this report are based on observation, interview, review of clinical records and other facility documentation, as indicated. The facility census on the first day of the survey was sixty-eight (68). The survey sample size was fourteen (14) residents. Abbreviations/definitions used in this report are as follows: CNA - Certified Nursing Assistant; DON - Director of Nursing; ED - Executive Director; IPP - Individual Program Plan; LPN - Licensed Practical Nurse; RCT - Resident Care Technician; RN - Registered nurse;	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tarah Pappas
TITLE: Executive Director
(X6) DATE: 03/09/2026 & 4/1/2026

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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W 000	Continued From page 1 Epilepsy - a long term brain disease that causes repeated seizures due to abnormal electrical signals produced by brain cells; IPP - a formal written plan that states specific objectives necessary to meet client's needs as identified by the comprehensive assessment; Medical plan of care - a comprehensive plan that includes a written plan of care established by a physician; Profound intellectual disability - condition where individuals are completely dependent on others for all ADLs and to maintain their physical health and safety; Seizure - abnormal electrical activity in the brain that temporarily affects consciousness, muscle control and behavior.	W 000 W 102	**Federal Tag W102-**"The facility must ensure that specific governing body and management requirements are met." **SECTION A (Individual Impacted)** As was evidenced in the findings, it was determined that The Mary Campbell Center's Governing Body, also known as its Board of Directors, failed to ensure sufficient operational directives regarding active treatment and health care services, failed to ensure client records were accurate and updated, and failed to ensure outside services were coordinated. These deficient practices impacted four residents (C3, C2, C10, C7). 1. Resident C3 - On February 12, 2026, the facility contacted C3's supervisor at DHSS who stated that "we feel this request is against her rights". The QIDP continues to work through other ways to satisfy the request. The QIDP again contacted C3s supervisor on March 7, 2026 to arrange a site visit, no response has been received to date. **2.** Resident C2 - Resident behaviors are documented in social support plans and not in the IPP. Resident C2 has a social support plan for worrying and anxiety. This information is reviewed at the quarterly mental health team meetings. Resident C2s Electronic Medical Record (EMR) does not include documentation of poor impulse control, being socially inappropriate or a poor problem solver.E8 provided incorrect information to the surveyor regarding C2. It is likely E8 confused C2 with another resident. **3.** Resident C7 - Resident C7's IPP Activities goal, created in September 2025, states "I will engage in programs for cognitive and sensory stimulation for increased social interactions". The intervention for this goal was also created in September 2025, Resident E7 "will engage in programs using his communication methods (I-Talk -2, Step-by-step, Switch, eye gaze, etc.) to engage in cognitive support and sensory stimulation 3 times per session (Baseline: 3 prompts; Frequency: 2x/mo; TD: 09/23/2026)". E7's inability to communicate why the use of the Snoezelen Room assisted the client with independence and active treatment is the result of the facility's failure to provide adequate training. **4.** Resident C10 is not referenced in the summary statement of deficiencies.	
W 102	GOVERNING BODY AND MANAGEMENT CFR(s): 483.410 The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on record review, facility document review, and interview, the facility failed to meet the Condition of Participation: Governing Body for four of 10 sample Clients (Client (C) 3, C2, C10, and C7). The Governing Body failed to ensure operational directions on policies were provided for active treatment and health care services, failed to ensure client records were accurate and			

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W 102	Continued From page 2 updated, and failed to ensure outside services were coordinated. This had the potential for clients not to consistently receive active treatment that meets their assessed needs. Findings include: 1. The facility failed to ensure that the Governing Body provided operational directions on policies for active treatment and health care services for clients. Cross Reference: W104. 2. The facility failed to ensure a client's records content was an accurate, functional representation of the client in the facility. Cross Reference: W111. 3. The facility failed to ensure that outside services were coordinated to meet the needs of the client. Cross Reference: W120.	W 102	**SECTION B (Identification of other residents)** All 68 residents are impacted by these deficient practices. **SECTION C (System Changes)** 1)The following is a proposed amendment to the Bylaws of The Mary Campbell Center Incorporated. "The Board is responsible for ensuring the Center meets all regulatory requirements of its license as an Intermediate Care Facility for Individuals with Intellectual Disabilities including the provision of Active Treatment." 2)The policy and procedure committee policy was revised to include a member from the Governing Body who has final authority regarding policies and procedures (Attachment Z) **SECTION D (Success Evaluation)** The Governing Body representative(s) will review and approve five policies and procedures each month until all policies have been reviewed. Policy review progress will be presented at committee meetings of The Board of Directors.	3/19/2026 COMPLETED
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interview, facility document review, and policy review, the facility failed to ensure the Governing Body provided operational direction on policies for active treatment, qualifications of the Qualified Intellectual Disabilities Professional (QIDP) health care services, such as clinical standards for clients who have seizures. In addition, the facility failed to offer clients and/or their representatives' pneumococcal vaccines. This had the potential for all 68 clients to have a diminished quality of life.	W 104	**Federal Tag W104** "The governing body must exercise general policy, budget and operating direction over the facility." *Content continues next page*	

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W 104	Continued From page 3 Findings include: 1.During an interview on 01/30/26 at 1:05 PM, the Executive Director (Employee (E) 1), Clinical Operations Coordinator (E30), the Director of Nursing (E2), and the lead QIDP/(E5) were present. E1 stated that the governing body met on a quarterly basis. E1 stated he/she understood what active treatment was and stated that there were some clients who had their own checking account and Amazon accounts and the clients can access their money at any time. E1 stated there was one client who never met her niece and the client wrote a book and completed the artwork and the facility published the book for the client. E1 stated he/she would pull active treatment reports for the governing body to review. E5 stated there was a check list that he/she used when training the new QIDPs. E5 stated the new QIDPs were not given a caseload of clients until after 90 days of training. Review of a document provided by the facility titled "Dashboard for Mary Campbell Center Committee - Active Treatment" dated 09/01/25 to 12/31/25, indicated key performances with graphs. The key performances included: group activities, led by skilled therapy and activities; trips; physical programs; and volunteers. The second page included a report located under the title " Long Term Care Evaluations Completed" which identified several activities that clients completed during this quarter which were all identified as client successes. There was no evidence identified that the facility implemented a comprehensive functional assessment (CFA) which clearly identified what a client can and cannot do and the skills necessary to prevent regression. The document failed to address that	W 104	**SECTION A (Individual Impacted)** As was evidenced in the findings, it was determined that The Mary Campbell Center's Governing Body, also known as its Board of Directors, failed to ensure sufficient operational directives regarding active treatment, qualifications for the Qualified Intellectual Disabilities Professionals, and health care services, specifically standards for clients who have seizures and for the distribution/ documentation of pneumococcal vaccines. These deficient practices impacted two residents (C1 and C12). The DON integrated the medical care plan of treatment into the IPP as a healthcare plan for seizures for C1. Resident C1 is scheduled to receive the pneumococcal vaccine on March 10, 2026. Resident C12 was discharged from the facility on February 5, 2026. The facility failed to ensure E5, E7 and E8 had the qualification to perform the functions of a QIDP in a setting that served persons with intellectual disabilities.	

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W 104	Continued From page 4 the CFA lead to the development of Individual Service Plan (IPP) which served as the basis of clients to achieve an active treatment program. There was no identified direction provided by the Governing Body on how to correct this deficient practice. There was no direction provided by the Governing Body that addressed the required background, which was a full year of working with Individuals with Intellectual Disabilities, prior to hiring a QIDP. Review of a facility policy titled "Organization and Purposes" undated indicated ". . . The mission of MCC shall be to promote the general welfare of persons with disabilities and other special needs (mentally, physically, or both) through the operation of a unique, state of the art facilities with a specially trained and committed staff employing a broad array of individually designed programs and services for those persons involved in the intermediate and skilled care residential. . ." There was no mention of active treatment in the Governing Body policies to correct potential deficient practice. There was no direction from the Governing Body policies to correct potential deficient practices related to active treatment, by way of the CFA to IPP development, or to the QIDP qualifications. 2. 1/30/25 10:45 AM - During an interview, E2 (DON) stated that any clients requiring a seizure protocol would be documented in the client's care plan and IPP, and any medications would be under physician's orders. E2 stated that the facility did not have a seizure protocol established prior to April 15, 2025. E2 confirmed that seizure protocol and education was initiated after the aforementioned date.	W 104	**SECTION B (Identification of other residents impacted.)** All 68 residents have the potential to be impacted by these deficient practices. **SECTION C (System Changes)** The following is a proposed amendment to the Bylaws of The Mary Campbell Center Incorporated. "The Board is responsible for ensuring the Center meets all regulatory requirements of it's license as an Intermediate Care Facility for Individuals with Intellectual Disabilities(ICF/IID) including the provision of Active Treatment." A member of the Governing Body will join the Policy and Procedure Committee to ensure policies meet regulatory requirements. The following policies have been revised since the survey team exit date: (Attachment A, G, and Z) Pneumococcal Vaccine Policy IPP Policy Policy and Procedure Committee An Active Treatment Policy will be completed on or before March 19, 2026.	

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W 104	Continued From page 5 Review of C1 and C12's care plan and IPP lacked evidence of a seizure protocol. The care plan and IPP documented risk of injury related to seizure and appropriate interventions to prevent. There was no mention of seizure protocol in the Governing Body policies to correct potential deficient practice. There was no direction from the Governing Body policies to correct potential deficient practices related to seizure protocols in the facility. 3. 1/29/26 12:10 PM - During an interview, E15 (RN Policy Nurse) stated that the facility follows the guidance and recommendation of the CDC and the IP (Infection Preventionist Nurse) will do a sweep every January to ensure client's are up to date on vaccines. Review of C1 and C12's medical record that both client's were not up to date on pneumococcal vaccine's per the provider recommendation. There was no mention of vaccine process in the Governing Body policies to correct potential deficient practice. There was no direction from the Governing Body policies to correct potential deficient practices related to vaccine recommendations in the facility.	W 104	**SECTION D (Success Evaluation)** All new and revised policies will be audited by the ED to ensure reviewed and signed by a Board member weekly until consistency reaches 100% success for one month THEN All new and revised policies will be audited by the ED to ensure reviewed and signed by a Board member monthly until consistency reaches 100% success for 3 months FINALLY. All new and revised policies will be audited by the ED to ensure reviewed and signed by a Board member quarterly until consistency reaches 100% success for one year.Audit results will be shared with the Governing Body Representaitve at the quarterly QAA meetings.	3/19/2026 COMPLETED
W 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by:	W 111	**Federal Tag W111** "The facility must develop and maintain a record keeping system that includes a separate record for each client and that documents the client's health care, active treatment, social information and protection of the client's rights."	

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W 111	Continued From page 6 Based on observation, record review, interview, and document review, the facility failed to ensure a record contained an accurate updated comprehensive functional assessment (CFA), failed to update when the client completed goals, and failed to carry this update to the clients Individual Program Plan (IPP). Additionally, the facility failed to ensure the clients active treatment program addressed his/her assistance with nutrition and completion of an educational binder for self-advocacy for one Client (Client (C) 3) out of survey sample of 10 clients. Findings include: Review of a document provided by the facility for C3 titled "Resident Face Sheet" indicated the facility admitted the client to the facility on 06/07/11. Review of a document provided by the facility for C3 titled "CFA" dated 02/26/25 indicated that the client was dependent on staff to be fed. The CFA indicated that the client was offered a choice to feed him/her during meals. The adaptive equipment that was to be used was an over the shoulder sling to be applied to the client's right side and a dignity spoon with two loops for the client to hold. There was no mention in the client's CFA that the client was to develop a binder for self-advocacy. Review of a document provided by the facility for C3 titled "IPP" dated 03/20/25 indicated the client was to be provided with a sling and dignity spoon with finger loops. In addition, IPP identified C3 completed the development of an informational binder to support the client with self-advocacy and emergency procedures on 06/19/25. There	W 111	**SECTION A (Individual Impacted)** The Interdisciplinary Team completes a Comprehensive Functional Assessment (CFA) annually for each resident. Assessment findings are used to create the resident's Individualized Program Plan (IPP), which is person-centered and includes resident goals and objectives for the upcoming year. Resident progress in achieving IPP goals is documented every three months in Quarterly IPP Progress Updates. The CFA, IPP, and Quarterly IPP Progress Updates are maintained in the residents' Electronic Medical Record (EMR). IPP Goals can be found under the Care Plan tab in the residents' EMR. Program Plans are reviewed at least quarterly and on an annual basis by the Responsible Party (RP). The RP is a member of the Interdisciplinary Team and is responsible for collaborating with residents to create their IPP goals. (Attachment – G) The facility failed to follow the Individualized Program Plan Policy and Procedure, and the IPP Goal/Revision Policy and Procedure for Resident C. (Attachment – H) Please note: Attachments G and H reflect policies revised since the survey exit date. The deficient practice impacting Resident C3 was corrected on 3/3/2026 by Occupational Therapy and Nursing. A new goal was added for this resident. Occupational Therapy and Nursing – Goal #4 to "Increase my independence and frequency with my self-feeding program." (Attachment – I) Education – Goal #5 "I will create an informational binder to help support self-advocacy for use at home and in the community." (Attachment – I (2) Education – Goal #6 "I will successfully complete Wilmington University coursework, fieldwork, and other professional projects." (Attachment – I (4) Case Management – Goal #7 "I will investigate a digital banking tool to assist with financial management." (Attachment – I (3) **SECTION B (Identification of other residents)** All residents have the potential to be affected by the deficient practice. Using the IPP Program Implementation Tool, (Attachment J). QIDPs and the Director of Nursing or designee will review resident records to identify residents where the facility failed to follow the Individualized Program Plan Policy and Procedure and the IPP Goal/ Revision Policy and Procedure. Interdisciplinary Team members will meet with residents who are identified as having goals that do not reflect their annual IPP or are no longer relevant. Team members will collaborate with residents to revise existing goals and/or develop new goals. IPP goals will be documented in the residents EMRs	

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W 111	Continued From page 7 was no mention of a measurable goal to provide the client with a sling and dignity spoon with finger loops to utilize during dining. During an observation on 01/27/26 at 4:19 PM, Registered Nurse/Employee (E)10 assisted C3 with his/her dinner meal. The client was not observed with a sling on or used a dignity spoon to feed him/herself. During an observation and interview on 01/29/26 at 12:30 PM, C3 was assisted with eating by E10. E10, who was also the nursing supervisor, stated that C3 did have a splint and stated the splint was not used every day. E10 confirmed the client did not utilize a dignity spoon. During an interview on 01/28/26 at 10:50 AM, the lead Qualified Intellectual Disabilities Professional/E5 stated clients' CFAs and IPPs were updated on an annual basis.	W 111	**SECTION C (System Changes)** The Staff Educator or designee will train ID Team and nursing staff on the revised Individualized Program Plan, including integration of the Medical Care Plan of Treatment into Health Care Plans, and PP Goal/Revision policies.QIDPs will utilize the IPP Program Implementation Tool to audit compliance with the revised Individualized Program Plan policy and procedure. The Director of Nursing or designee will review the Medical Care Plan of Treatment (Attachment K), the nursing section of the Comprehensive Functional Assessment (Attachment L), and quarterly Nursing Assessments (Attachment M) to ensure Health Care Plans are comprehensive and correct. The Director of Nursing or designee will notify nursing staff when Health Care Plans do not accurately reflect the resident's medical needs. QIDPs will notify Interdisciplinary Team members (RPs) when residents' goals do not reflect their annual IPP, Quarterly IPP Progress Updates, or are no longer relevant. The RPs will meet with residents within two weeks of being notified by Case Managers/QIDPs. RPs will collaborate with residents to revise existing goals and/or develop new goals. **SECTION D (Success Evaluation)** QIDPs and the Director of Nursing or designee will review resident records on or before March 19, 2026, to ensure IPP goals and Health Care Plans follow the revised IPP Policy and Procedure. Audit results will be documented using the IPP Program Implementation Tool. (Attachment J). Results of EMR reviews will be presented at the next Quality Assessment and Assurance Committee meeting. After March 19, 2026, QIDPs and the Director of Nursing will review five resident records per week to ensure 100% compliance with the IPP Policy for twelve consecutive weeks. Then, ten resident records will be reviewed monthly until 100% compliance is met for three consecutive months. After that time, twelve resident records will be reviewed quarterly. The quarterly review requirement will be ongoing, with results reported at Quality Assessment and Assurance Committee meetings.	3/19/2026 COMPLETED
W 120	SERVICES PROVIDED WITH OUTSIDE SOURCES CFR(s): 483.410(d)(3) The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that outside services were coordinated to meet the needs of one Client (Client (C) 3) out of a survey sample of 10. This failure had the potential to result in inconsistent implementation of client programs and interruption of necessary services. Findings include:	W 120		

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W 120	Continued From page 8 Review of a document provided by the facility for C3 titled "Resident Face Sheet" indicated that the facility admitted the client on 06/07/11. Review of a document provided by the facility for C3 titled "Comprehensive Functional Assessment (CFA)" dated 02/26/25 indicated the client had employment in the community. Review of a document provided by the facility for C3 titled "Individual Program Plan (IPP) dated 03/20/25, failed to indicate specific goals with measurable outcomes for the coordination of community services for the client. During an interview on 01/29/26 at 3:48 PM, the Executive Director/Employee (E) 1 stated C3 met the criteria for admission into an Intermediate Care Facility (ICF) based on limited mobility, expression, and self-care. E1 stated the client was his/her own decision maker and gained employment on his/her own. During an interview on 01/28/26 at 10:50 AM, Qualified Intellectual Disabilities Professional Manager/E5 stated that he/she meets with C3 after her work schedule to go over what happened during the day. During an interview on 01/29/26 at 7:52 AM, C3 confirmed he/she had outside employment and was considered a state employee. During an interview on 01/29/26 at 3:48 PM, E1 stated there was no agreement in place between the facility and C3's place of employment since the client obtained the job on her own.	W 120	**W120 – REVISED.** The facility must assure that outside services meet the needs of each client. **Section A: Individual/Resident Impacted.** The facility failed to ensure that outside services met the needs of Resident C3. No other residents were affected by the deficient practice. (Attachment AA) **Section B: Identification of other residents with the potential to be affected.** Resident records were reviewed to identify other residents who receive outside services. No other residents are impacted by this deficient practice. **Section C: System Changes.** QIDPs will adhere to the QIDP Documentation Guidelines and coordinate quarterly site visits to ensure outside services meet the needs of residents. Additional training for QIDPs will be conducted on QIDP Documentation Guidelines by the Staff Educator or designee. (Attachment EE; formerly Attachment N) **Section D: Success Evaluation.** The QIDP or designee will conduct quarterly visits to locations where residents receive outside services to ensure their Active Treatment needs are being met. The QIDP or designee will complete the Residents Outside Services Audit Tool. (Attachment FF; formerly Attachment O) The QIDP Manager or designee will report site visit audit results to the Quality Assessment and Assurance Committee quarterly until 100% compliance is achieved for four consecutive quarters.	**3/19/2026 COMPLETED**
W 158	FACILITY STAFFING	W 158		

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W 158	Continued From page 9 CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure that the Qualified Intellectual Disability Professionals (QIDPs)/Employee (E)5, E7, and E8 were qualified, adequately trained, and actively involved in providing active treatment to assist three Clients (C)3, C2, and C7) in skill development and to prevent potential regression. E5, E7, and E8 failed to coordinate active treatment services, which included educational, vocational opportunities, behavioral support, health care services, and the active acquisition of new skills. The had the potential to affect all 68 clients of the facility. Findings include: 1. The facility failed to implement an effective active treatment program, failed to coordinate community services, failed to observe interactions between clients and staff, and failed to understand their role in developing active treatment by completing a comprehensive functional assessment. Cross Reference: W159. 2. The facility failed to ensure staff were qualified with one year of experience that served individuals with intellectual disabilities prior to being employed by the facility. Cross Reference W160.	W 158	**SECTION A (Individual Impacted)** The facility failed to ensure that QIDPs were qualified, adequately trained and act vely involved in providing Active Treatment. A current employee who is now a Registered Nurse, formally a QIDP, will provide training on Active Treatment and the role and responsibilities of QIDPs. **SECTION B (Identification of other residents)** This deficient practice has the potential to affect 68 residents. **SECTION C (System Changes)** 1.The QIDP and QIDP Manager job descriptions were updated to include required experience stating, "At least one year of work experience working directly with individuals with intellectual disabilities or developmental disabilities." (Attachment P and Q) 2.QIDPs, E5, E7, and E8 revised their resumes to include experience working directly with persons with intellectual or other developmental disabilities. (Attachment R, S, T) 3.A current employee who is now a Registered Nurse, formally a QIDP, will provide training on Active Treatment and the role and responsibilities of QIDPs. (Attachment U). 4.Provide annual Active Treatment Training for QIDP staff online or in person. 5.New hire orientation for QIDPs will include training on Active Treatment and role and responsibilities of a QIDP. (Attachment V) **SECTION D (Success Evaluation)** The QIDPs will be assigned a test on or before March 19, 2026 to evaluate their understanding of Active Treatment and the roles and responsibilities of a QIDP. The results will be reported to the Executive Director. Anyone not achieving 100% will receive remedial training and be retested until 100% success is achieved.	**3/19/2026 COMPLETED**
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be	W 159	W 159 - **REVISED.** QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated, and monitored by a qualified mental retarcation professional.	

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W 159	Continued From page 10 integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on interview, record review, and facility document review, the facility failed to ensure the Qualified Intellectual Disabilities Professional (QIDP)/Employee (E) 5, E7, and E8 coordinated and monitored clients' active treatment program for three of four Clients (C)3, C2, and C7). The failure to coordinate and monitor the clients' active treatment program could lead to fragmented services and a decline in overall functional status. Findings include: 1. Review of a document provided by the facility titled "Resident Face Sheet" indicated that the facility admitted C3 on 06/07/11. During an interview on 01/28/26 at 10:50 AM, E5, who was the QIDP Manager, stated he/she did not go to C3's work area to ensure that active treatment was provided. E5 stated that C3 was an independent person and could advocate for him/herself and has worked in the community since 2013. E5 stated the client has been in his/her current position for the past year. E5 was asked to define active treatment. E5 stated that the facility met as an interdisciplinary team (IDT) to assess each client. E5 stated that the IDT goes over the IPP and goals for the year of the client. 2. Review of a document provided by the facility titled "Resident Face Sheet" indicated that the facility admitted C2 on 08/06/01. During an interview on 01/29/26 at 12:28 PM QIDP/E8 was asked to define active treatment.	W 159	**Section A: Individual/Resident Impacted.** The facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the QIDP. Residents C2, C3 and C7 were affected by this deficient practice. The facility failed to ensure that outside services met the needs of Resident C3. Resident C3 has an IPP goal for obtaining additional work skills. (Attachment AA) Residents C2 and C7 did not receive aggressive, consistent and individualized active treatment programs because the facility failed to ensure the QIDPs were adequately trained. A current employee who is now a Registered Nurse, formally a QIDP at The Mary Campbell Center, will provide training on Active Treatment and the role and responsibilities of QIDPs **Section B: Identification of other residents with the potential to be affected.** This deficient practice has the potential to affect 68 residents. Resident records will be reviewed to identify residents where the facility failed to follow the Individualized Program Plan Policy and Procedure and the IPP Goal/Revision Policy and Procedure. (Attachment G & H) **Section C: System Changes.** A current employee who is now a Registered Nurse, formally a QIDP at The Mary Campbell Center, will provide training on Active Treatment and the role and responsibilities of QIDPs. New hire orientation for QIDPs will include training on Active Treatment and role and responsibilities of a QIDP. (Attachment U & V)	

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W 159	Continued From page 11 E8 stated active treatment was treatment to a client who was open to assistance. When asked about providing clients with active treatment E8 stated his/her goal was to make a person's day better. 3. Review of a document provided by the facility titled "Resident Face Sheet" indicated that the facility admitted C7 on 09/13/13. During an interview on 01/29/26 at 12:12 PM QIDP/E7 defined active treatment as all the clients were involved in therapy programs based on functionality and mobility. E7 stated that clients were not required to participate in all of the activities and this was why the clients' have an individualized IPP. Review of a document provided by the facility titled "Active Treatment Training" undated indicated ". . .It is directed, whenever possible, by the resident and/or the closet advocate (often the QIDP). . ."	W 159	**Section D: Success Evaluation.** QIDPs and the Director of Nursing or designee will review resident records on or before March 19, 2026, to ensure IPP goals and Health Care Plans follow the revised IPP Policy and Procedure. Audit results will be documented using the IPP Program Implementation Tool. Results of EMR reviews will be presented at the next Quality Assessment and Assurance Committee meeting. After March 19, 2026, QIDPs and the Director of Nursing will review five resident records per week to ensure 100% compliance with the IPP Policy for twelve consecutive weeks. Then, ten resident records will be reviewed monthly until 100% compliance is met for three consecutive months. After that time, twelve resident records will be reviewed quarterly. The quarterly review requirement will be ongoing, with results reported at Quality Assessment and Assurance Committee meetings. (Attachment J)	3/19/2026 COMPLETED
W 160	QIDP CFR(s): 483.430(a)(1) The qualified mental retardation professional has at least one year of experience working directly with persons with mental retardation or other developmental disabilities. This STANDARD is not met as evidenced by: Based on interview, document review, and application review, the facility failed to ensure two Qualified Intellectual Disabilities Professional (QIDP)/Employee (E) 5 and E8 had one year of experience in a setting that served persons with intellectual disabilities. Since QIDP plays a significant role in the coordination of active	W 160	W 160 The qualified mental retardation professional has at least one year experience working directly with persons with mental retardation or other developmental disabilities.	

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W 160	Continued From page 12 treatment for individuals with intellectual disabilities, the lack of experience could impact planning, implementation, and ensure that oversight of clients' needs were met. This has the potential to affect 68 out of 68 residents who resided in the facility. Findings include: 1. Review of E5's application and resume failed to contain evidence of one year working with clients who were intellectually disabled. The date of hire for E5 was 01/28/25. 2. Review of E8's application and resume failed to contain evidence of one year working with clients who were intellectually disabled. The date of hire for E8 was 06/03/25. During an interview on 01/30/26 at 8:57 AM, the Vice President of Human Resources/Employee (E) 4 went through the applications for E5 and E7 and confirmed the staff did not have a year of experience working with the intellectually disabled. E4 stated that the facility discussed the one-year experience working with intellectually disabled in the past but had not updated the job description. Review of a job description provided by the facility titled "Job Description. . . Case Manager/QIDP" undated indicated ". . . The Case Manager/Qualified Intellectual Disability Professional (QIDP)/Case Manager is responsible for coordinating active treatment and related services for residents and ensuring they are delivered with a high degree of [quality in a homelike environment where. . .residents live with respect, personal dignity, and independence to	W 160	**Section A: Individual Resident Impacted.** The facility failed to ensure that E5 and E8 had one year of experience in a setting that served persons with intellectual disabilities. **Section B: Identification of other residents with the potential to be affected.**All residents had the potential to be affected by the deficient practice. **Section C: System Changes** •The QIDP and QIDP Manager job descriptions were revised to include required experience stating, "At least one year of working experience working directly with individuals with intellectual disabilities or developmental disabilities." (Attachment P & Q) •QIDPs, E5,and E8 revised their resumes to include experience working directly with persons with intellectual or other developmental disabilities. (Attachment R & T) **Section D: Success Evaluation** As needed, the Executive Director will ensure newly hired QIDPs meet the requirements in the job description. This information will be reported to the Governing Body at quarterly Management and Personnel Committee meetings. (Attachment W)	

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W 160	Continued From page 13 the fullness of their abilities. The Case Manager/QIDP acts as the resident's primary advocate in coordinating services as the . . .QIDP. . .ensuring an individualized and comprehensive active treatment program appropriate to each resident in an assigned caseload. . ." The job description failed to contain evidence of the one year of experience working with clients who were intellectually disabled.	W 160		3/19/2026 COMPLETED
W 195	ACTIVE TREATMENT SERVICES CFR(s): 483.440 The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observations, interviews, record review, and policy review, the facility failed to ensure a continuous active treatment program, which included the use of adaptive equipment during meals, behavioral, educational/vocational training and supporting a client, through clear and measurable goals to live in the community. This failure has the potential for clients not to receive continuous active treatment programs and were at risk of failing to acquire necessary functional, adaptive, behavioral, educational, and vocational skills. Findings include: 1.Standard W196: The facility failed to ensure that three Clients' (C) 3, C2, and C7 treatment program included consistent implementation of specialized and generic training, treatment, health	W 195	**W195 –** The facility must ensure that specific active treatment services requirements are met. **Section A: Individual/Resident Impacted.** Residents C2, C3 and C7 were affected by this deficient practice. Resident C2; behaviors are documented in social support plans and not in the IPP. Resident C2 has a social support plan for worrying and anxiety. This information is reviewed at the quarterly mental health committee meetings. (Attachment X) Resident C2s EMR does not include documentation of poor impulse control, being socially inappropriate or a poor problem solver. It appears E8 provided incorrect information to the surveyor regarding C2. Resident C3's IPP was revised to include goals in money management, education, and working in the community. (Attachments I3, I4, and I5) Education – Goal #6 "I will successfully complete Wilmington University coursework, fieldwork, and other professional projects." (Attachment – I (4) Case Management – Goal #7 "I will investigate a digital banking tool to assist with financial management." (Attachment – I (3) Case Management – Goal #8 "I will receive support to maintain successful employment in the community." (Attachment – I (5) Resident C7's IPP Activities goal created in September 2025 states "I will engage in programs for cognitive and sensory stimulation for increased social interactions". The intervention for this goal was also created in September 2025, E7 "will engage in programs using his communication methods (I-Talk -2, Step-by-step, Switch, eye gaze, etc) to engage in cognitive support and sensory stimulation 3 times per session (Baseline: 3 prompts; Frequency: 2x/mo; TD: 09/23/2026)". The facility's failure to adequately train E7 resulted in their inability to effectively communicate why the use of the Snoezelen Room assisted the client with independence and active treatment. **Section B: Identification of other residents with the potential to be affected.** Any resident has the potential to be affected by the deficient practice. Utilizing the IPP Program Implementation Tool, residents IPP goals will be reviewed to ensure that specific active treatment services requirements are met. (Attachment J)	

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W 195	Continued From page 14 services, and related services directed toward achieving the client's highest level of independence. 2.Standard W198: The facility failed to ensure C3 received active treatment in money management. 3.Standard W224: The facility failed to ensure C3 was provided with an active treatment program which involved education. 4.Standard W225: The facility failed to ensure C3 was provided with an active treatment program which focused on working in the community.	W 195	**Section C: System Changes.** QIDPs will utilize the IPP Program Implementation Tool to audit IPP active treatment goals. QIDPs will notify Interdisciplinary Team members (RPs) when residents' goals do not reflect their active treatment needs. The RPs will meet with residents within two weeks of being notified by QIDPs. RPs will collaborate with residents to revise existing goals and/or develop new goals. (Attachment G & J) As mentioned in W159; E5, E7 and E8 will receive additional training on Active treatment and the role and responsibilities of QIDPs. **Section D: Success Evaluation.** QIDPs and the Director of Nursing or designee will review resident records on or before March 19, 2026, to ensure IPP goals and Health Care Plans follow the revised IPP Policy and Procedure. Audit results will be documented using the IPP Program Implementation Tool. (Attachment J). Results of EMR reviews will be presented at the next Quality Assessment and Assurance Committee meeting. After March 19, 2026, QIDPs and the Director of Nursing will review five resident records per week to ensure 100% compliance with the IPP Policy for twelve consecutive weeks. Then, ten resident records will be reviewed monthly until 100% compliance is met for three consecutive months. After that time, twelve resident records will be reviewed quarterly. The quarterly review requirement will be ongoing, with results reported at Quality Assessment and Assurance Committee meetings.	3/19/2026 COMPLETED
W 196	ACTIVE TREATMENT CFR(s): 483.440(a)(1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies and procedures, the facility failed to ensure that three of four Clients (Client (C) 3, C2, and C7) treatment program included consistent implementation of specialized and generic training, and related services directed toward	W 196		

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W 196	Continued From page 15 achieving the client's highest level of independence. This failure resulted in C3 not receiving essential components of active treatment, which had the potential to reduce the client's independence and impede progress toward community readiness. The facility failed to address C2's emotional outbursts in active treatment. Finally, the facility failed to address C7's difficulty in communication and the use of the Snoezelen room (multi-sensory room) as part of his/her active treatment program. Findings include: 1. Review of a document provided by the facility titled "Resident Face Sheet" indicated that the facility admitted C3 on 06/07/11. Review of a document provided by the facility for C3 titled "Comprehensive Functional Assessment (CFA)" dated 02/26/25, indicated that the client was employed. In addition, the CFA indicated that the client was to live in the community. During an interview on 01/28/26 at 10:50 AM, E5, who was the QIDP Manager, stated he/she did not go to C3's work area to ensure that active treatment was provided. E5 stated that C3 was an independent person and could advocate for him/herself and has worked in the community since 2013. E5 stated the client has been in his/her current position for the past year. E5 was asked to define active treatment. E5 stated that the facility met as an interdisciplinary team (IDT) to assess each client. E5 stated that the IDT goes over the IPP and goals for the year of the client and this included C3's continuation of his/her education. E5 stated he/she has a performance plan for C3 and presented this document during	W 196	**W196 – REVISED.** Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal function status. **Section A: Individual/Resident Impacted.** Residents C3, C2 and C7 were impacted by this deficient practice. Resident C3's IPP wil be revised to include goals to support successful employment in the community and explore options for living in the community. Case Management – Goal #8 "I will receive support to maintain successful employment in the community." Resident C3's IPP 2025-2026 Goal #8 was revised (now 2026-2027 Goal #6). (Attachment AA; formerly Attachment I(5) Case Management – Goal # "I will explore options for living in the community." (Attachment – I (6) Resident behaviors are documented in social support plans and not in the IPP. Resident C2 has a social support plan for worrying and anxiety. This information is reviewed at the quarterly mental health committee meetings. Resident C2's SSP goal and interventions were revised. (Attachment CC; formerly Attachment X)	

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W 196	Continued From page 16 the interview. Review of a document provided by the facility titled "The State of Delaware Performance Plan" dated 12/01/24 indicated that the Manager of Family Engagement/E26 was the supervisor of C3. The performance plan addressed accountability, communication, professionalism, leadership, attendance, compliance, and teamwork. There was no evidence to indicate that the work location was involved in active treatment for C3 nor was there information that the QIDP monitored the client's active treatment. 2. Review of a document provided by the facility titled "Resident Face Sheet" indicated that the facility admitted C2 on 08/06/2001 Review of a document provided by the facility for C2's "Individual Program Plan (IPP)," dated 02/11/25 failed to indicate measurable goals with a timeline, to address that the client had behavioral outbursts, had poor impulse control, and could be socially inappropriate at times. Review of a document provided by the facility for C2 titled "CFA" dated 07/15/25 indicated that the client had a history of anxiety and depression. The CFA indicated the client had poor impulse control, could be socially inappropriate at times, and was a poor problem solver. During an interview on 01/29/26 at 12:28 PM QIDP/E8 stated that C2 has verbal aggression especially when another person did not understand what C2 stated. E8 stated the client had difficulty with not being able to verbalize and pronounce words. E8 stated that this behavior could be a barrier for the client to socialize with	W 196	Resident C2s EMR does not include documentation of poor impulse control, being socially inappropriate or a poor problem solver. It appears E8 provided incorrect information to the surveyor regarding C2. Resident C7's IPP Activities goal created in September 2025 states "I will engage in programs for cognitive and sensory stimulation for increased social interactions". The intervention for this goal was also created in September 2025, E7 "will engage in programs using his communication methods (I-Talk -2, Step-by-step, Switch, eye gaze, etc.) to engage in cognitive support and sensory stimulation 3 times per session (Baseline: 3 prompts; Frequency: 2x/mo; TD: 09/23/2026)". Resident C7: IPP Goal 2025- 2026: Goal #2 Activities (Attachment DD) **Section B: Identification of other residents with the potential to be affected.** This deficient practice has the potential to affect 68 residents. Resident records will be reviewed to identify residents where the facility failed to follow the Individualized Program Plan Policy and Procedure and the IPP Goal/Revision Policy and Procedure. (Attachment G, H, & J)	

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W 196	Continued From page 17 others. E8 was asked why the client's emotional outbursts were not incorporated into the IPP and E8 stated that the IDT has worked with the client for a while and his/her outbursts were seldom. 3. Review of a document provided by the facility titled "Resident Face Sheet" indicated that the facility admitted C7 on 09/13/13. Review of a document provided by the facility titled "CFA" dated 02/26/25 indicated that C7 used step-by-step communicators, and other low technology augmentative and alternative communication (AAC), such as communication books or picture cards to replace speech. The CFA specifically identified the use of "Italk4" which is an augmentative communication device to make choices and to engage in communication opportunities. In addition, there was no information that the client would benefit from Snoezelen room for the reduction of anxiety/depression and/or to enhance communication. Review of a document provided by the facility titled "IPP" dated 09/02/25 revealed that C7's IPP goals included: to engage in programs for cognitive and sensory stimulation and social interaction. The IPP was not specific with interventions and failed to have associated measurable goals. During an interview on 01/29/26 at 12:12 PM QIDP/E7 stated C7 used a communication board while in the Snoezelen room and it was used to enhance communication. E7 was unable to communicate why the use of the Snoezelen room assisted the client with independence and active treatment.	W 196	**Section C: System Changes** a. A current employee who is now a Registered Nurse, formally a QIDP, will provide training on Active Treatment and the role and responsibilities of QIDPs. (Attachment P, Q, U, &V) b. Provide annual Active Treatment Training for QIDP staff online or in person. c. The QIDPs will be assigned a test to evaluate and ensure their understanding of Active Treatment and the roles and responsibilities of a QIDP. The results will be reported to the Executive Director. Anyone not achieving 100% will receive remedial training and be retested until 100% success is achieved. **Section D: Success Evaluation.** The QIDP Manager or designee will review five resident records per week for compliance with the IPP policy to determine the QIDPs understanding of Active Treatment and their role and responsibilities. Weekly reviews will be conducted until 100% compliance is met for twelve consecutive weeks. Then, ten resident records will be reviewed monthly until 100% compliance is met for three consecutive months. After that time, twelve resident records will be reviewed quarterly. The quarterly review requirement will be ongoing, with results reported at Quality Assessment and Assurance Committee meetings. (Attachment J)	3/19/2026 COMPLETED

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W 198	ADMISSIONS, TRANSFERS, DISCHARGE CFR(s): 483.440(b)(1) Clients who are admitted by the facility must be in need of and receiving active treatment services. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure one Client (Client (C) 3) out of a survey sample of 10 received active treatment in money management. Failure to ensure that the client received active treatment placed the client at risk for functional decline and potential mismanagement of money. Findings include: Review of a document provided by the facility titled "Resident Face Sheet" indicated that the facility admitted C3 on 06/07/11. Review of a document provided by the facility for C3 titled "Comprehensive Functional Assessment (CFA)" dated 02/26/25, indicated that the client understood the concept of money and how to make change up to 10 dollars. Review of a document provided by the facility for C3 titled "Individual Program Plan (IPP)" dated 03/20/25 failed to contain evidence that the client was on a money management program. During an interview on 01/28/26 at 10:50 AM, E5, who was the QIDP Manager, stated that the client managed his/her own money and this was not included in the client's CFA or the IPP. E5 stated that money management was not part of the client's IPP but was a case manager's responsibility.	W 198	**W198 –** Clients who are admitted by the facility must be in need of and receiving active treatment services. **Section A: Individual/Resident Impacted.** Resident C3 was impacted by this deficient practice. C3s IPP was revised to include goals in money management. Case Management – Goal #7 "I will investigate a digital banking tool to assist with financial management." (Attachment – I (3) **Section B: Identification of other residents with the potential to be affected.** This deficient practice has the potential to affect 68 residents. The Comprehensive Functional Assessments were reviewed to determine which residents can identify currency. On or before March 19, 2026 Money Management IPP goals will be implemented for those residents who can identify currency. **Section C: System Changes.** The Staff Educator or designee will train ID Team and nursing staff on the revised Individualized Program Plan Policy and Procedure, which states "Comprehensive Functional Assessment, is reviewed by the ID Team at the meeting held prior to the resident's scheduled IPP meeting. The RPs will make recommendations for the resident's active treatment IPP goal based on outcomes of their assessment and interviewing the resident". (Attachment G)	

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W 198	Continued From page 19 During an interview on 01/29/26 at 3:48 PM, the Executive Director/Employee (E)1 stated that active treatment was to provide clients with access to their money 24/7. E1 stated there were some clients who used a check book and/or had an Amazon account. E1 was unable to explain why the IPP failed to contain measurable goals.	W 198	**Section D: Success Evaluation.** The QIDP Manager or designee will review five resident records per week for compliance with the IPP policy to determine the QIDPs understanding of Active Treatment and their role and responsibilities. Weekly reviews will be conducted until 100% compliance is met for twelve consecutive weeks. Then, ten resident records will be reviewed monthly until 100% compliance is met for three consecutive months. After that time, twelve resident records will be reviewed quarterly. The quarterly review requirement will be ongoing, with results reported at Quality Assessment and Assurance Committee meetings. (Attachment J)	3/19/2026 COMPLETED
W 224	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure one Client (Client (C) 3) out of a survey sample of 10, was provided with an active treatment program which involved education. The clients' Individual Program Plan (IPP) lacked measurable objectives and/or consistent implementation addressing identified skill deficits, and staff were unable to demonstrate how interventions were systematically provided, monitored, and adjusted to promote the client's independence and community functioning. Findings include: Review of a document provided by the facility titled "Resident Face Sheet" indicated that the facility admitted C3 on 06/07/11. Review of a document provided by the facility for C3 titled "Comprehensive Functional Assessment (CFA)" dated 02/26/25 indicated the client was in school.	W 224	**W224 –** Adaptive behaviors or independent living skills necessary for the client to be able to function in the community. **Section A: Individual/Resident Impacted.** Resident C3 was impacted by this deficient practice. C3's IPP was revised to include an education goal to assess support services needed to complete coursework. Education – Goal #6 "I will successfully complete Wilmington University coursework, fieldwork, and other professional projects." (Attachment – I (4) **Section B: Identification of other residents with the potential to be affected.** All resident records were reviewed. There are no other residents impacted by this deficient practice. **Section C: System Changes.** The Staff Educator or designee will train ID Team and nursing staff on the revised Individualized Program Plan Policy and Procedure, which states "The Comprehensive Functional Assessment, is reviewed by the ID Team at the meeting held prior to the resident's scheduled IPP meeting.	

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W 224	Continued From page 20 Review of a document provided by the facility for C3 titled "IPP" dated 03/20/25 failed to address the client's goal of attending college. There were no measurable short-term goals, no identified skill development, tied to the educational goal. During an interview on 01/29/26 at 7:52 AM, C3 stated her active treatment did include her education. C3 stated that he/she completed her undergraduate degree in 2024 and that was the same year he/she began her master's program. During an interview on 01/29/26 at 1:07 PM, Qualified Intellectual Disabilities Professional Manager/Employee (E)5 stated that it was a team approach to develop goals for a client. E5 stated that C3 had goals of graduating with his/her master's degree and when asked about specific goals developed in the IPP, E5 stated that C3 was able to advocate for him/herself with the completion of her education.	W 224	The RPs will make recommendations for the resident's active treatment IPP goal based on outcomes of their assessment and interviewing the resident." (Attachment G) **Section D: Success Evaluation.** The QIDP Manager or designee will review five resident records per week for compliance with the IPP policy to determine the QIDPs understanding of Active Treatment and their role and responsibilities. Weekly reviews will be conducted until 100% compliance is met for twelve consecutive weeks. Then, ten resident records will be reviewed monthly until 100% compliance is met for three consecutive months. After that time, twelve resident records will be reviewed quarterly. The quarterly review requirement will be ongoing, with results reported at Quality Assessment and Assurance Committee meetings. (Attachment J)	3/19/2026 COMPLETED
W 225	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include, as applicable, vocational skills. This STANDARD is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to ensure one Client (Client (C)3) out of a survey sample of 10, was provided with an active treatment program which focused on working in the community. The clients' Individual Program Plan (IPP) IPP lacked measurable objectives and/or consistent implementation addressing identified skill deficits and successes in his/her current work environment.	W 225		

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W 225	Continued From page 21 Findings include: Review of a document provided by the facility titled "Resident Face Sheet" indicated that the facility admitted C3 on 06/07/11. Review of a document provided by the facility for C3 titled "Comprehensive Functional Assessment (CFA) dated 02/26/25 indicated that the client was employed. Review of a document provided by the facility for C3 titled "IPP" dated 03/20/25 failed to address the client's work. There were no measurable short-term goals, no identified skill development, or learning objectives identified, even though the client indicated he/she was employed and documentation in the CFA confirmed the client was employed. During an interview on 01/29/26 at 7:52 AM, C3 confirmed he/she had no active treatment support with his/her employment in the community. During an interview on 01/28/26 at 10:50 AM, Qualified Intellectual Disabilities Professional (QIDP) Manager/Employee (E) 5 stated C3 was a "Go getter" and likes to speak for him/herself. E5 stated the client connected to a vocational program and worked in the community and this was an independent decision apart from the facility. E5 stated that the decision for the client to gain employment was his/her choice. During an interview on 01/30/26 at 1:05 PM, the Executive Director/Employee (E) 1 stated that the client made the decision on his/her own to gain employment in the community.	W 225	**W225 – REVISED.** The comprehensive functional assessment must include, as applicable, vocational skills. **Section A. Individual/Resident Impacted.** Residents C3 was impacted by this deficient practice. The Comprehensive Functional Assessment (CFA) indicated Resident C3 "has paid employment in the community". IPP Goal 2026 – 2027: Goal #6 Case Management & Education. (Attachment AA; formerly Attachment I(5)) **Section B. Identification of other residents with the potential to be affected.** All resident records were reviewed. There are no other residents impacted by this deficient practice. **Section C: System Changes.** The Staff Educator or designee will train ID Team and nursing staff on the revised Individualized Program Plan Policy and Procedure, which states "The Comprehensive Functional Assessment, is reviewed by the ID Team at the meeting held prior to the resident's scheduled IPP meeting. The Responsible Person (RP) will make recommendations for the resident's active treatment IPP goals based on outcomes of their assessment and interviewing the resident". (Attachment G)	

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W 225	Continued From page 22 Review of the facility's policy titled ". . .IPP. . . dated 05/20/25 indicated ". . .Each resident living in the ICF/IID will have an Individualized Program Plan (IPP) developed by an Interdisciplinary Team (ID Team), the resident and/or resident's representative, and family members as requested by the resident. Program Plans will be reviewed on an annual basis; at least quarterly by the Responsible Party (RP). . ." The policy failed to address that the QIDP was to ensure the IPP had measurable, skill-based objectives related to identified needs which included vocational functioning.	W 225	**Section D: Success Evaluation.** The QIDP Manager or designee will review five resident records per week for compliance with the IPP policy to determine the QIDPs understanding of Active Treatment and their role and responsibilities. Weekly reviews will be conducted until 100% compliance is met for twelve consecutive weeks. Then, ten resident records will be reviewed monthly until 100% compliance is met for three consecutive months. After that time, twelve resident records will be reviewed quarterly. The quarterly review requirement will be ongoing, with results reported at Quality Assessment and Assurance Committee meetings. (Attachment J)	3/19/2026 COMPLETED
W 318	HEALTH CARE SERVICES CFR(s): 483.460 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on interviews, record review, and policy review, the facility failed to ensure that two clients (C1 and C12) were provided with standard nursing services for the recognition of signs/symptoms of seizures by clinical staff, seizure management, and control when a client has a seizure or a history of seizures. In addition, the facility failed to follow Centers for Disease Control (CDC), a nationally recognized standard of practice for recommendations for pneumococcal vaccination for C1 and C12. This had the potential for the clients to have unmet care needs. Findings include: 1. The facility failed to to integrate the medical	W 318	**W318-** Health Care Services CFR 483.460- The facility must ensure that specific health care services requirements are met. **Section A: Individuals affected.** The facility failed to integrate the medical care plan of treatment with the IPP for residents C1 and C12. The DON integrated the medical care plan of treatment into the IPP as a healthcare plan for seizures for C1. C12 was discharged from the facility on 2/5/2026. (Attachment Y) The facility failed to follow the pneumococcal vaccine policy and procedure. Resident C1 is scheduled to receive the pneumococcal vaccine 3/10/2026. C12 was discharged from the facility on 2/5/2026. (Attachment A) **Section B: Identification of other residents with the potential to be affected by the deficient practice.** All residents have the potential to be affected by deficient practices. The Infection Preventionist audited residents EMR and identified 66 residents who need a pneumococcal vaccine to comply with the CDC adult immunization schedule. Sixty-two residents have consented to receive the vaccine on March 10, 2026. Four residents declined the vaccine.	

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W 318	Continued From page 23 care plan of treatment with the IPP. The facility lacked evidence of the medical care plan being integrated with the IPP for C1 and C12. Cross Reference: W321. 2. The facility failed to provide preventative and general care. The facility lacked evidence of C1 and C12 being up to date on pneumococcal vaccination for C1 and C12. Cross Reference: W322. 2/2/26 4:00 PM - Findings were reviewed with E1 (ED) and E2 (DON) during the exit conference.	W 318	**Section C: System Changes** Under the direction of the medical provider, Registered Nurses will create a medical care plan of treatment. The medical care plan of treatment will be integrated into the health care plans by registered nurses. This will be reviewed at the IPP annually and quarterly IPP progress update. (Attachment G and K) The Infection Preventionist or designee will follow the updated pneumococcal vaccine policy and procedure. (Attachmert A). **Section D- Success Evaluation** The DON or designee will review five resident records per week for compliance with the IPP policy to ensure the medical care plan of treatment is integrated into the IPP as a healthcare plan(s). Weekly reviews will be conducted until 100% compliance is met for twelve consecutive weeks. Then, ten resident records will be reviewed monthly until 100% compliance is met for three consecutive months. After that time, twelve resident records will be reviewed quarterly. The quarterly review requirement will be ongoing, with results reported at Quality Assessment & Assurance Committee meetings. (Attachment J) The Infection Preventionist or designee will follow the revised pneumococcal vaccine policy to ensure residents are up to date with the vaccine. The Infection Preventionist or designee will report pneumococcal vaccine rates at the QAA meetings. Vaccination rates will be added to the QAA meeting agenda.	3/19/2026 COMPLETED
W 321	PHYSICIAN SERVICES CFR(s): 483.460(a)(2) The medical care plan of treatment must be integrated in the individual program plan. This STANDARD is not met as evidenced by: Based on interview and record review for two (C1 and C12) out of twelve clients reviewed for IPP (Individualized Program Plan) the facility failed to integrate the medical care plan of treatment with the IPP. Findings include: 1. Review of C1's clinical record revealed: 8/16/09 - C1 was admitted to the facility with following diagnoses: profound intellectual disability, chromosomal abnormalities, and generalized idiopathic epilepsy. 2/5/25 - A Individual Program Plan (IPP) documented that C1 was at risk for injuries related to seizures and the following interventions were implemented: labs as ordered; maintain safety during seizure activity; administer anti-seizure activity as ordered; document seizure	W 321	**W321-Physician Services:** The medical care plan of treatment must be integrated in the IPP.	

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MARY CAMPBELL CENTER	4641 WELDIN RD WILMINGTON, DE 19803

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W 321	Continued From page 24 activity on administration record; notify physician of any acute changes in client's pattern of seizure activity; and ensure safety devices are in place. 2/2/26 2:20 PM - During an interview with E1 (ED), E2(DON), E5 (QIDP Manager) and E15 (RN Policy Nurse) stated that the facility does not review client's for a medical plan of treatment for any client's who require 24-hour licensed care. It was also determined that the facility lacked evidence of integrating the medical treatment care plan to coordinate C1's IPP due to the IPP addressing safety concerns and not plan of care related to seizures. 2. Review of C12's clinical record revealed: 4/12/07 - C12 was admitted to the facility with the following diagnoses: profound intellectual disability and seizure disorder. 8/11/21 - A Individual Program Plan (IPP) documented that C12 was at risk for injuries related to seizures and the following interventions were implemented: assess the frequency, duration, and type of seizure activity; labs as ordered; maintain safety during seizure activity; administer anti-seizure activity as ordered; document seizure activity on administration record; notify physician of any acute changes in client's pattern of seizure activity; and ensure safety devices are in place. 2/2/26 2:20 PM - During an interview with E1 (ED), E2(DON), E5 (QIDP Manager) and E15 (RN Policy Nurse) stated that the facility does not review client's for a medical plan of treatment for any client's who require 24-hour licensed care. It was also determined that the facility lacked	W 321	**Section A. Individuals impacted.** 1.The facility failed to integrate the medical care plan of treatment with the IPP for residents C1 and C12. The DON integrated the medical care plan of treatment into the IPP as a healthcare plan for seizures for C1. C12 was discharged from the facility on 2/5/2026. (Attachment Y) **Section B: Residents with the potential to be affected.** All resident have the potential to be affected by the deficient practice. **Section C. System Changes:** Under the direction of the medical provider, Registered Nurses will create a medical care plan of treatment. The medical care plan of treatment will be integrated into the health care plans by registered nurses. This will be reviewed at the IPP annually and quarterly IPP progress update. (Attachment G & K) **Section D- Success Evaluation:** The DON or designee will review five resident records per week for compliance with the IPP policy to ensure the medical care plan of treatment is integrated into the IPP as a healthcare plan(s). Weekly reviews will be conducted until 100% compliance is met for twelve consecutive weeks. Then, ten resident records will be reviewed monthly until 100% compliance is met for three consecutive months.	

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W 321	Continued From page 25 evidence of integrating the medical treatment care plan to coordinate C12's IPP due to the IPP addressing safety concerns and not plan of care related to seizures. The facility failed to integrate a medical care plan of treatment with the formulation of C1 and C12's IPP. The IPP lacked evidence of medication use and addressed safety precaustions related to seizure activity. 2/2/26 4:00 PM - Findings were reviewed with E1 (ED) and E2 (DON) during the exit conference.	W 321	**Section D: (Continued)** After that time, twelve resident records will be reviewed quarterly. The quarterly review requirement will be ongoing, with results reported at Quality Assessment and Assurance Committee meetings. (Attachment J)	**3/19/2026 COMPLETED**
W 322	PHYSICIAN SERVICES CFR(s): 483.460(a)(3) The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review for two (C1 and C12) out of six reviewed for infection control, the facility failed to provide preventative and general care. Findings include: A facility policy dated November 2021 documented "Resident's of the Mary Campbell Center will be vaccinated with the pneumococcal vaccine in accordance with the Centers for Disease Control and Prevention (CDC) recommendations." 5/24/25 - The CDC recommendation documents "the pneumococcal vaccine recommended for children and adults at increased risk for pneumococcal disease." 1. Review of C1's clinical record revealed:	W 322	See content page 28-9.	

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W 322	Continued From page 26 8/16/09 - C1 was admitted to the facility with following diagnoses: profound intellectual disability, chromosomal abnormalities, and generalized idiopathic epilepsy. 9/28/19 - A standing physician's order documented that C1 was to receive the pneumococcal vaccine per CDC recommendation and last dose received 12/6/17. 1/29/26 12:10 PM - During an interview, E15 (RN Policy Nurse) stated that the facility follows the guidance and recommendation of the CDC and the IP (Infection Preventionist Nurse) will do a sweep every January to ensure client's are up to date on vaccines. E15 confirmed the last sweep was completed in 1/2024 and the current IP is working on a sweep for 2026 currently. 1/30/26 2:24 PM - During an interview, E32 (Physician) stated that clients are reviewed annually during the annual physical to determine who is due for vaccines. E32 stated the expecatation is if a client had already received the pneumococcal vaccine to continue to the process of receiving every five years per CDC recommendation. 2/2/26 11:01 AM - During an interview, E33 (IP) stated that C1 was not due for a pneumococcal vaccine due to age requirements and was not included in the current client sweep to administer. E33 provided documentation that C1 received a pneumococcal vaccine on 3/21/19. E33 confirmed that C1 was not current if following the five year recommendation per E32 expectation. 2. Review of C12's clinical record revealed:	W 322	See content next page.	

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W 322	Continued From page 27 4/12/07 - C12 was admitted to the facility with the following diagnoses: profound intellectual disability and seizure disorder. 12/10/24 - A standing physician's order documented that C12 was to receive the pneumococcal vaccine per CDC recommendation and last dose received 12/6/17. 1/29/26 12:10 PM - During an interview, E15 (RN Policy Nurse) stated that the facility follows the guidance and recommendation of the CDC and the IP (Infection Preventionist Nurse) will do a sweep every January to ensure client's are up to date on vaccines. E15 confirmed the last sweep was completed in 1/2024 and the current IP is working on a sweep for 2026 currently. 1/30/26 2:24 PM - During an interview, E32 (Physician) stated that clients are reviewed annually during the annual physical to determine who is due for vaccines. E32 stated the expecatation is if a client had already received the pneumococcal vaccine to continue to the process of receiving every five years per CDC recommendation. 2/2/26 11:01 AM - During an interview, E33 (IP) stated that C1 was not due for a pneumococcal vaccine due to age requirements and was not included in the current client sweep to administer. E33 provided documentation that C12 received a pneumococcal vaccine on 3/21/19. E33 confirmed that C12 was not current if following the five year recommendation per E32 expectation. 2/2/26 4:00 PM - Findings were discussed with E1 (ED) and E2 (DON) during the exit	W 322	**W322** The facility must provide or obtain preventative and general medical care. **Section A – Individual(s) impacted.** The facility failed to follow the pneumococcal vaccine policy and procedure. Resident C1 is scheduled to receive the pneumococcal vaccine on March 10, 2026. C12 was discharged from the facility on 2/5/2026. (Atttachment A) **Section B – Identification of Other Residents with the potential to be affected by the deficient practice.** The Infection Preventionist audited residents EMR and identified 66 residents who need a pneumococcal vaccine to comply with the CDC adult immunization schedule. Sixty-two residents have consented to receive the vaccine on March 10, 2026. Four residents declined the vaccine. **Section C – System Changes** The Infection Preventionist or designee will follow the updated pneumococcal vaccine policy and procedure. The revision includes "The Infection Preventionist or designee will review residents medical records to ensure they are following the CDC Adult Immunization Schedule for Pneumococcal Vaccines". (Attachment A)	

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W 322	Continued From page 28 conference.	W 322	**Section D – Success Evaluation** The Infection Preventionist or designee will follow the revised pneumococcal vaccine policy to ensure residents are up to date with the vaccine. The Infection Preventionist or designee will report pneumococcal vaccine rates at the quarterly QAA meetings.	**3/19/2026 COMPLETED**