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: Exceptional Care for Children

DATE SURVEY COMPLETED: May 19, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced annual and complaint survey was conducted at this facility from May 12, 2026, through May 19, 2026. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was forty-four (44). The survey sample size was fifteen (15). Abbreviations/definitions used in this report are as follows: CNA – Certified Nursing Aid; DON – Director of Nursing; MD – Medical Director; NHA – Nursing Home Administrator RN – Registered Nurse Tuberculosis (TB) – a contagious infection that affects the lungs; Quantiferon – a blood test used to check if a person has been exposed to the bacteria that causes tuberculosis. **Title 16, DE Administrative Code** **Regulations for Skilled and Intermediate Care Facilities** **Scope** **This requirement was not met as evidenced by:** Cross refer to CMS 2567-L survey completed on May 19, 2026: F609 and F880. **Services To Residents** **Communicable Diseases** **Specific Requirements for Tuberculosis**	**3201.6.9.2.4.1** **No person, including volunteers, found to have active tuberculosis in an infectious stage shall be permitted to give care or service to residents.** **1. Corrective Action for Resident(s) Affected by the Deficient Practice** Upon identification of the positive second-step TB skin test for Employee E13, the employee was removed from the work schedule effective 8/4/25 and prohibited from providing resident care pending further evaluation. Employee E13 was referred to the Delaware Division of Public Health on 8/15/25 A chest x-ray completed on 8/15/25 was interpreted as normal, and a QuantiFERON-TB Gold test completed on 8/29/25 resulted as negative. The employee was subsequently evaluated by the Delaware Division of Public Health and cleared to return to work on 9/2/25. A retrospective review of employee work assignments and resident exposure was completed. No residents were identified as having signs, symptoms, or confirmed exposure related to active tuberculosis. The employee remained asymptomatic throughout the evaluation process. **2. Identification of Other Residents or Employees Who May Be Affected** The Director of Human Resources, Infection Preventionist, and Director of Nursing conducted a retrospective audit of all employee health files for current employees hired within the previous 12 months to verify:	6/24/26

Provider's Signature Michell Campbell Title Administrator Date 6/24/26

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3201. 6.9.2.4 3201.6.9.2.4.1 S/S – E	**Minimum requirements for pre-employment tuberculosis (TB) testing require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron.** **No person, including volunteers, found to have active tuberculosis in an infectious stage shall be permitted to give care or service to residents.** This requirement was not met as evidenced by: Based on interviews and review of facility documents, it was determined that the facility failed to ensure TB testing was completed prior to a staff member being employed to provide direct resident care. Additionally, the facility failed to remove the employee from direct resident care after the employee's second TB skin test was read as positive on 8/1/26. Findings include: 7/23/25 - E13 was hired as a CNA. The first step TB test was administered to E13. 7/25/26 – E13's first step TB skin test was read as negative 7/30/26 – The second step TB skin test was administered to E13. 7/31/26 – E13 worked evening/night shift providing direct resident care. 8/1/26 – E13 worked evening/night shift providing direct resident care. 8/1/26 11:53 PM – E13's second TB skin test was read as positive. On 8/1/26 at 11:53 PM,	• Completion of required baseline TB screening prior to assignment to resident care duties. • Documentation of completed two-step TST or approved IGRA testing. • Appropriate follow-up for any positive TB screening result. • Documentation of clearance before employee assignment or return to resident care responsibilities. Any identified variances were immediately corrected prior to employees providing resident care. **3. Measures Put Into Place to Ensure the Deficient Practice Does Not Recur** The facility revised its pre-employment health screening process to ensure compliance with Delaware regulations and CDC/CMS infection prevention requirements. Revised TST policy to ensure consistent compliance with implementation of tuberculosis screening requirements. The following measures have been implemented: • No employee, contractor, agency staff member, student, or volunteer will be permitted to provide resident care or services until all required TB screening requirements have been completed and documented. • Administer First PPD during onboarding paperwork session (pre-employment)	

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	E14 (RN) emailed a photograph of E13's positive skin test to E6 (RN, Clinical Support Services Manager). 8/2/26 – E13 worked evening/night shift providing direct resident care. 8/3/26 – E13 worked evening/night shift providing direct resident care. 8/4/26 – E13 was removed from the work schedule 8/15/26 – E13 had a chest x-ray which was read as "Normal." E13 was referred to the State Division of Public Health 8/29/26 – E13's QuantiFeron (blood test that checks for TB) result was negative. 9/2/26 – E13 was cleared by the State Division of Public Health to return to work. 5/18/26 10:40 AM - During an interview, E5 (Director of Human Resource) confirmed that E13 worked the evening/night shift of 8/1/26 – 8/3/26 providing direct resident care. 5/18/26 11:00 – An interview E6 (RN) revealed that the email with E13's positive TB skin test result was emailed to her Friday, 8/1/26, at 11:53 PM. E6 stated that she did not receive the email until the morning of 8/4/26. E13 was removed from the schedule on 8/4/26 and was referred to the Division of Public Health TB Clinic. The facility failed to initiate TB testing prior to E13 being assigned to provide direct resident care. Additionally, the facility failed to remove E13 from direct resident care when a positive second test was identified.	• Second PPD must be administered first day of orientation, prior to resident care • The Human Resource department, Education department and/or designee will verify completion of all pre-employment health requirements before activating the employee to work with residents. • Any employee receiving a positive TST result will be immediately removed from all schedules pending medical evaluation and clearance by an authorized healthcare provider and/or the Delaware Division of Public Health. • A revised notification process has been implemented requiring positive TB test results to be communicated directly by telephone to the Human Resource department, Infection Preventionist, Director of Nursing, or on-call nursing administrator in addition to any electronic communication. • Education was provided to Human Resources personnel, nursing leadership, staffing coordinators, and employee health personnel regarding: • Delaware TB screening requirements. • Facility pre-employment screening procedures. • Requirements for immediate exclusion from all schedules	

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	5/19/26 3:45 PM - Findings were reviewed with E1 (NHA) and E3 (DON) during the exit conference.	when a positive TB screening result is identified pending evaluation and clearance. • Escalation and reporting procedures for abnormal employee health findings. **4. Monitoring to Ensure Continued Compliance** The Director of Human Resources, education staff, infection preventionist or designee will audit 100% of newly hired employee files prior to the employee's first scheduled shift to verify: • Required TB screening was completed. • Appropriate documentation is present. • Any positive results received appropriate follow-up and clearance. • No employee was assigned to resident care before meeting all requirements. Audit frequency: • Weekly for 4 weeks • Monthly for 3 months thereafter. Audit results will be reported to the facility's Quality Assurance and Performance Improvement (QAPI) Committee monthly for review and analysis. The QAPI Committee will determine the need for additional corrective actions based on audit findings.	

Provider's Signature Michell Campbell Title Administrator Date 6/24/26

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEPTIONAL CARE FOR CHILDREN	11 INDEPENDENCE WAY , NEWARK, Delaware, 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
F0000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from May 12, 2026, through May 19, 2026. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was forty-four (44). The survey sample size was fifteen (15). Abbreviations/definitions used in this report are as follows: Diazepam - a medication used to treat anxiety, agitation, and control muscle spasms and stiffness; DON - Director of Nursing; Enhanced Barrier Precautions (EBP): Wearing gloves and gowns during certain types of care, to help prevent the spread of germs; G-tube: A tube placed directly into the stomach through the abdomen to provide food, fluids, or medications; G/J Tube: A feeding tube that goes into both the stomach and the small intestine to provide food, fluids, or medications; LPN - Licensed Practical Nurse; MD - Medical Director; Multidrug-Resistant Organisms (MDROs): Germs that are difficult to treat because they do not respond to common antibiotics; NHA - Nursing Home Administrator; PA - Physician Assistant; RN - Registered Nurse; Spastic Quadriplegic Cerebral Palsy (SQCP) - a severe condition that affects the nervous system causing significant muscle stiffness in all four limbs	F0000		06/05/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0000	Continued from page 1 and trunk of body; Tracheostomy: A breathing tube placed through an opening in the neck to help a person breathe; Tracheostomy Stoma: The opening in the neck where the breathing tube is inserted;	F0000		06/05/2026
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F0880	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	06/24/2026

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F0880 SS = E	Continued from page 2 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that for four (R13, R21, R24, and R27) out of twenty-two sampled residents, the facility failed to ensure enhanced barrier precautions (EBP) were followed. Findings include: According to the CDC (Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs, Updated July 12, 2022), Nursing home residents with wounds or indwelling medical devices, such as catheters, tracheostomies (breathing tubes), or feeding tubes, are more likely to get and carry these germs. Enhanced Barrier Precautions (EBP) are designed to reduce the spread of these germs. EBP includes the use of a gown and gloves when	F0880	Continued from page 2 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Deficiency: Failure to ensure staff consistently implemented Enhanced Barrier Precautions (EBP) per facility policy and CDC guidance. Facility Response: Immediate corrective actions have been taken to address the identified gaps in adherence to	06/24/2026

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F0880 SS = E	Continued from page 3 providing "high contact" care to these residents. "High contact" care includes dressing, bathing, transferring, providing hygiene, changing linens, device care, and wound care." Review of the facility's policy and procedure for Enhanced Barrier Precautions, last reviewed 1/26, revealed that "... Enhanced Barrier Precautions are implemented for all Exceptional Care for Children residents due to existing indicators; currently all residents have at least one indicator..." Staff are to wear gowns and gloves for "all high contact resident care activities," which includes "device care and use." 1. Review of R13's record revealed: 5/22/24 – R13 was care planned for EBP related to G tube (feeding tube) and tracheostomy (breathing tube). Interventions include "Gowns/gloves will be worn by staff during close contact interventions." 05/12/26 1:08 PM - P1 (Medical Doctor), and E10 (RN) were observed in the community playroom evaluating R13. P1 and E10 were not wearing gowns while assessing R13's tracheostomy stoma, ears, and mouth. 5/12/26 2:21 PM – A progress note by E10 documented, "...Trach (sic) stoma, mouth and ears assessed with drainage noted from L ear..." 2. Review of R24's record revealed: 5/22/24 – R24 was care planned for EBP related to G/J tube (feeding tube) and tracheostomy. Interventions include "Gowns/gloves will be worn by staff during close contact interventions." 5/12/26 1:08 PM - P1 and E10 were observed in the community playroom evaluating R24. P1 and E10 were not wearing gowns while assessing R24's tracheostomy stoma, ears, and mouth. 5/12/26 2:34 PM - A progress note by E10 documented, "...Trach stoma, mouth and ears assessed with no concerns..." 3. Review of R21's record revealed: 5/22/24 – R21 was care planned for EBP related to G/J tube and tracheostomy. Interventions include "Gowns/gloves will be worn by staff during close contact interventions."	F0880	Continued from page 3 Enhanced Barrier Precautions. The facility has reinforced staff education, clarified expectations for when and how EBP must be implemented, and strengthened monitoring systems to ensure consistent compliance with CDC recommendations and facility policy. Ongoing oversight mechanisms have been established to sustain compliance and reduce the risk of transmission of multidrug-resistant organisms and other healthcare-associated infections. 1. Corrective Action for Affected Residents (R13, R21, R24, R27) The affected resident(s) were assessed for any signs or symptoms of infection. No adverse outcomes were noted. Staff involved were re-educated immediately on Enhanced Barrier Precautions, including use of gowns and gloves during all high-contact care activities regardless of location. Care plans for affected residents were reviewed and validated to ensure proper EBP interventions. Infection surveillance showed no signs or symptoms of infection in these residents. 2. Identification of Other Residents at Risk: An audit was conducted on all residents requiring Enhanced Barrier Precautions to ensure care plans, and supplies were in place. All residents were identified at risk due to facility wide EBP policy and all residents requiring EBP during high contact care activities. 100% audit of all residents was completed by 5/20/2026 to ensure appropriate EBP care plans. All residents were reviewed to confirm correct implementation of precautions. No additional residents were identified as negatively	06/24/2026

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F0880 SS = E	Continued from page 4 5/12/26 1:15 PM – P2 (PA) was observed in the community playroom evaluating R21. P2 was not wearing gowns while assessing R21's tracheostomy stoma, ears, and mouth. 4. Review of R27's record revealed: 5/22/24 – R27 was care planned for EBP related to G/J tube and tracheostomy. Interventions include "Gowns/gloves will be worn by staff during close contact interventions." 5/14/26 approximately 2:45 pm – E9 (RN) was observed in the community playroom administering medications to R27 through the G/J-tube. E9 was not wearing a gown. 5/14/26 approximately 3:00 PM – Interview with E9 revealed that staff do not follow EBP when administering medications through feeding tubes while residents are in the common areas. 5/18/26 approximately 1:00 PM - An interview with E10 revealed that facility staff, including providers, do not follow EBP when rounding or caring for residents in the playroom. E10 stated that EBP "is not something we have to do" when the residents are cared for in the playroom. 5/18/26 approximately 2:00 PM – During an interview, findings were reviewed and confirmed with E6 (RN, Clinical Support Services Manager). 5/19/26 3:45 PM – Findings were reviewed with E1 and E3 during the exit conference.	F0880	Continued from page 4 impacted. 3. Systemic Changes to Prevent Recurrence: Re-Education provided to all clinical staff including physicians on Enhanced Barrier Precautions: Indications for EBP Required PPE for high-contact care activities no matter the location Importance of compliance to prevent transmission of multidrug-resistant organism EBP policy revised (05/25/2026) to clarify use in all settings including common areas and define high-contact care. Competency validation completed for staff on proper PPE use. DON/Nurse Educators/Infection Preventionists/designees will conduct daily observational rounding and real time corrective action PPE availability (gowns and gloves) standardized and monitored to ensure accessibility. 4. Monitoring to Ensure Sustained Compliance: Nursing Administration/Nurse Educators/Infection Preventionist or designee will perform: Weekly audits x 4 weeks, then Monthly audits x 3 months, focusing on proper implementation of EBP during high-contact care activities	06/24/2026

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F0880 SS = E		F0880	Continued from page 5 Compliance threshold set at 100% with immediate corrective action for non-compliance Audit results will be reviewed weekly by leadership and in quarterly Quality Assurance and Performance Improvement (QAPI) meetings. Ongoing noncompliance will result in immediate re-education and progressive disciplinary action as applicable. 5. Date of Compliance: Full compliance is expected by: ____6/24/2026_____	06/24/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was	F0609	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Deficiency: Failure to immediately report to law	06/24/2026

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F0609 SS = D	Continued from page 6 determined that for one (R41) out of one resident reviewed for resident rights, the facility failed to have evidence of notification to law enforcement after a controlled medication was not returned to the facility. Findings include: Review of R41's clinical record revealed: 7/30/2024 – R41 was admitted to the facility with diagnoses including spastic quadriplegic cerebral palsy. 1/23/26 – An order entered in R41's clinical record documented, "diazepam – Schedule IV [controlled substance] tablet…Special instructions: Give every 6 hours as needed for increased spasticity, prior to transport…". 4/3/26 1:53 PM – A Nursing Progress Note documented, "[FM1] arrived to pick up [R41] around 1230 [12:30 PM] for LOA [leave of absence]…[R41] left the facility…with all necessary equipment, medications, and tube feeding." 4/3/26 – A facility document entitled, "Resident Leave of Absence Request and Agreement" signed by FM1 documented, "…Any unused medication must be returned to the facility upon the resident's return…Medication Name: diazepam Dose: 3 mg [milligrams] Quantity Dispensed: 2 doses…". 4/5/26 12:43 AM – A Nursing Progress Note entered by E11(RN) documented, "[R41] returned to facility from LOA with [FM1]…All equipment returned…[FM1] refused to return the doses [diazepam] and put the two unused doses of diazepam back into her personal bag…Doses [diazepam] marked under missing supplies on LOA paperwork, on-call administrative team and DON notified via email…". 4/5/26 3:00 AM – A facility document entitled, "Patient Incident Report" was completed and signed by E11 documented, "…[R41] returned from LOA at 2355 [11:55 PM] instead of 2100 [9:00 PM]…[FM1] asked this nurse [E11] what is done with unused diazepam doses. [E11] stated that we have to properly dispose of them…[FM1] then put the diazepam (2 unused doses) back into her personal bag and stated, 'Well then I'm taking these back home to save for next time if you're just going to throw them out.'…admin [Administrator] on-call notified via email…". 4/15/26 1:29 PM – A Nursing Progress Note entered by E12 (ADON, LPN) documented, "On 4/6 [4/6/26] it was reported that [R41] returned from LOA with	F0609	Continued from page 6 enforcement of any reasonable suspicion of a crime against a resident. Facility Response: The facility has taken prompt corrective action to address the identified concern, to ensure that all staff clearly understand their obligations regarding mandatory reporting to law enforcement and the state agency, and to implement system changes that will prevent recurrence. Ongoing monitoring systems have been established to ensure sustained compliance with CMS regulations and to protect the health, safety, and welfare of all residents. Corrective Action for the Affected Resident R41 Immediately assessed R41 upon return from LOA to ensure no adverse physical or psychosocial outcomes related to the missing controlled medication. Notified the attending provider, no new orders were required as the resident was clinically stable and at baseline The incident was reviewed in full by DON and NHA State Survey Agency Notified Updated Policies Updated LOA paperwork Report was retroactively made to law enforcement as a suspected misappropriation of a controlled substance and documented: 6/4/2026 New Castle County Police Department Case Number: 32-26-043421	06/24/2026

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0609 SS = D	Continued from page 7 [FM1] and that [R41]'s 2 doses of prn (sic) [as needed] valium [diazepam] were unused…This nurse [E12] and DON have attempted to call [FM1] by phone since 4/7 [4/7/26]. On this day, this nurse texted [FM1] at 1049 [10:49 AM] requesting she call this nurse…". 4/20/26 1:11 PM – A Nursing Progress Note entered by E12 documented, "This nurse [E12] spoke with [FM1] regarding the 2 doses of prn (sic) [as needed] valium [diazepam] that was kept by guardian after last LOA. [FM1] informed that she cannot keep any unused narcotics that [facility] must dispose of them properly and keep proper records…". 5/4/26 10:25 AM – A Nursing Progress Note entered in R41's clinical record documented, "[FM1] returned narcotics from [R41]'s recent LOA. Medication was wasted by two nurses per policy." 5/19/26 10:00 AM – During an interview, E1 (NHA) stated, "I don't have any knowledge of any police reports or of law enforcement being contacted. I was on leave when this incident occurred. [E2, NHA] was the on-call Administrator at the time." 5/19/26 10:15 AM – During an interview, the surveyor asked E3 (DON) if law enforcement was notified when FM1 refused to return the diazepam medication. E3 stated, "The police were not notified. We updated the LOA policy for drug diversion after this incident to notify law enforcement." The surveyor asked E3 when law enforcement would be notified if a guardian does not return a controlled substance as agreed to the facility upon return from LOA, because it was not stated in the policy. E3 stated, "Law enforcement would be contacted because we don't want our nurses to get into an altercation or put themselves in danger." 5/19/26 10:30 AM – During an interview, E12 stated, "It was hard to get in contact with [FM1] to return the medication." The surveyor asked E12 when law enforcement would be notified if a parent or guardian does not return medication to the facility after LOA. E12 stated, "I don't know when the police would be contacted." 5/19/26 1:50 PM – During a telephone interview, E11 stated, "…I was taken aback when [FM1] would not return the diazepam." The surveyor asked "who you informed that FM1 refused to return the diazepam doses?" E11 stated, "I emailed the Nurse Administrator On-Call [E7], the Administrator On-Call [E2], and the DON [E3]." The surveyor asked E11 if she was aware of the updated LOA policy on	F0609	Continued from page 7 There was no need to replace the medication as the facility had ample amount as to not disrupt residents' plan of care Restricted the family member involved from handling, transporting, or possessing the resident's medications until the return of the medication and further education regarding LOA policies and procedures and the return of all unused medications including controlled substances. Medication was returned by the parent on 5/4/26 and wasted by nursing Reported the allegation to the appropriate state agency within required timeframes and documented date/time and method of reporting. A root cause analysis determined that lack of clear policy direction regarding law enforcement notification in cases of medication diversion involving family/guardians contributed to the deficiency. Corrective Action for Residents Potentially Affected An audit of all LOAs involving controlled substances for the past 90 days was completed by the DON. The audit included the review of: Medication reconciliations Incident reports LOA forms No additional incidents were identified where law enforcement notification was required and not completed. Education regarding the return of all controlled medications provided to all families who are approved to go on LOAs was completed including informing families if controlled substances that were not used were not returned law enforcement would	06/24/2026

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F0609 SS = D	Continued from page 8 drug diversion. E11 stated, "I believe we report it to the Administrator and the Education Team." The surveyor asked E11 if law enforcement would be contacted if medication is not returned to the facility when a resident comes back to the facility from LOA. E11 stated, "The LOA policy was changed for preventive education. I don't know if law enforcement was a route going to be taken." 5/19/26 2:00 PM – Findings were reviewed with E1. 5/19/26 3:45 PM – Findings were reviewed with E1 and E3 during the exit conference.	F0609	Continued from page 8 be notified. Systemic Changes to Prevent Recurrence The facility has implemented the following system wide corrective actions: Policy Revisions The Abuse Prevention and Reporting Policy were revised to explicitly identify medication diversion/misappropriation (including by family/guardians) as a reportable suspected crime under F609. Notification to be made within 24 hours of the alleged incident. Policy now clearly requires Immediate notification to Administrator and DON Reporting to law enforcement within CMS timeframes (Immediately when possible but no later than 2 hours if serious bodily injury; all other crimes within 24 hours) Updated LOA Policy to include: Strict accountability for controlled substances leaving and returning to the facility Clear directive that failure to return any controlled substances constitutes suspected diversion and triggers law enforcement notification Mandatory tracking of controlled substances leaving the facility. Defined accountability for return of medications. Standardized LOA Controlled Substance Agreement Form created and implemented:	06/24/2026

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F0609 SS = D		F0609	Continued from page 9 All parents/guardians must sign prior to LOA. Clearly states: Controlled substances must be returned if unused Failure to return will result in notification of law enforcement Re-educated all licensed nurses, supervisors, and leadership on: (a) definitions of abuse/neglect/exploitation/misappropriation, (b) required reporting timeframes, and (c) required law enforcement notification for suspected criminal activity including when related to misappropriation/diversion. All staff are individually responsible for reporting a suspected crime, this task cannot be delegated. Monitoring (Ongoing Audits) to Ensure Sustained Compliance DON/Designee will audit 100% LOAs including possibility of medication diversion (including medication diversion) for required notifications. Audit frequency: Weekly x 4 weeks, then Monthly x 3 months, with results reported in QAPI. Any identified concerns will result in QAPI. Immediate corrective action Re-education of staff as needed Policy reinforcement Compliance Goal: 100% Adherence Full Compliance Date	06/24/2026

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F0609 SS = D		F0609	Continued from page 10 Date of Compliance: 6/24/2026	06/24/2026