DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
261 Chapman Road Suite 200
Newark, DE 19702

STATE SURVEY REPORT

NAME OF FACILITY: Pike Creek Nursing & Rehabilitation Center **DATE SURVEY COMPLETED: September 10, 2024**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual, Complaint and Extended survey was conducted at this facility from July 29, 2024 through September 10, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 169. The investigative sample totaled 64 residents.		
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. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed September 10, 2024: F550, F552,	Cross Refer to the CMS 2567-L survey completed September 10, 2024: F550, F552, F580, F585, F600, F609, F656, F657, F677, F686, F688, F689,	10.24.2024

Provider's Signature __Brian Lenehan____ Title_______NHA_________________ Date _10.16.2024_______

NAME OF FACILITY: Pike Creek Nursing & Rehabilitation Center **DATE SURVEY COMPLETED: September 10, 2024**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	F580, F585, F600, F609, F656, F657, F677, F686, F688, F689, F690, F691, F695, F697, F726, F730, F756, F760, F791, F800, F804, F806, F809, F812, F842, F867, F883, F887, F941, F943, F944, F946, F947, and F949.	F690, F691, F695, F697, F726, F730, F756, F760, F791, F800, F804, F806, F809, F812, F842, F867, F883, F887, F941, F943, F944, F946, F947, and F949. Date of completion 10.24.2024	
3201.5.5.4	**Results of mandatory drug testing** **This requirement was not met as evidenced by:** Based on interview, record review and review of other facility documentation, it was determined that for two (E23 and E24) out of twelve employees sampled for drug testing the facility lacked evidence of mandatory drug testing being done. Findings include: 8/7/24 11:00 AM – During an interview E34 (HR) stated, "[E23 (CNA)] was agency staffing and a mandatory drug testing screen had not been done." In addition, E34 stated, "I told the agency they had until this afternoon for a drug screen to be done or "we the facility" are going to send E23 for the drug test." E34 then stated, "[E24 (CNA)] is being sent by the facility for a drug screen. E34 then stated, "I do know the facility went a few weeks without an HR person." 8/12/24 1:34 PM – Findings were confirmed with E2 (DON) and E3 (ADON). 8/12/24 2:15 PM – Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	3201.5.5.4 1.Upon discovery, staff members E23 and E 24 were removed from the schedule pending drug test completion. 2.All residents have the potential to be affected. 3.Human Resources Manager conducted an audit of all of employee files to ensure drug testing is up to date for all employees. For any files found lacking the required drug testing, the employees will be sent for drug testing and removed from the schedule until this step is completed. Human Resources Manager educated by Administrator on policy that drug testing must be completed and documented in the employee file prior to	10.24.2024

Provider's Signature _Brian Lenehan_ Title NHA Date _10.16.2024

NAME OF FACILITY: Pike Creek Nursing & Rehabilitation Center **DATE SURVEY COMPLETED: September 10, 2024**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		new employees completing orientation. 4.The HR Director or SDC will audit new hire files weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success with drug testing. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5.Date of completion: 10.24.2024	
3201.5.6	**Results of Dementia Training**		
3201.5.6.1	**Nursing facilities that provide direct health-care services to persons diagnosed as having Alzheimer's disease or other forms of demen-tia shall provide dementia specific training each year to those healthcare provviders who must participate in continuing education pro-grams. This section shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code.**		

Provider's Signature __*Brian Lenehan*____Title______NHA________________Date _10.16.2024______

NAME OF FACILITY: Pike Creek Nursing & Rehabilitation Center **DATE SURVEY COMPLETED: September 10, 2024**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201.5.6.2	**The mandatory training must include: communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to be taken with those persons.** **This requirement was not met as evidenced by:** Based on interview, record review and review of other facility documentation, it was determined that for three (E14, E27, and E28) out of nine sampled employees for dementia training the facility lacked evidence of dementia training being completed. Findings include; 9/1/22 E14 (CNA) was hired. The facility lacked evidence of dementia training being completed. 7/22/08 E27 (CNA) was hired. The facility lacked evidence of dementia training being completed. 10/3/23 E28 (CNA) was hired. The facility lacked evidence of dementia training being completed. 8/7/24 11:00 AM – During an interview E34 (HR) confirmed E14 (CNA), E27 (CNA) and E28 (CNA) had not completed dementia training. 8/12/24 1:34 PM – Findings were confirmed with E2 (DON) and E3 (ADON). 8/12/24 2:15 PM – Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	3201.5.6.2 1.Upon discovery, staff members E14, E27 and E28 were removed from the schedule pending dementia training completion. 2.All residents have the potential to be affected. 3.Human Resources Manager conducted an audit of all of employee files to ensure dementia training is up to date for all employees. For any files found lacking the required dementia training, the employees will be required to complete the necessary training and removed from the schedule until this step is completed. Human Resources Manager educated by Administrator on policy that dementia training must be completed and documented in the employee file each year for the employee to continue to be employed at the Center. orientation. 4.The HR Director or SDC will audit new hire files weekly x	10.24.2024

Provider's Signature _Brian Lenehan_ Title NHA Date 10.16.2024

NAME OF FACILITY: Pike Creek Nursing & Rehabilitation Center **DATE SURVEY COMPLETED: September 10, 2024**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success with dementia training. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5.Date of completion: 10.24.2024	
3201.6.9.2 3201.6.9.2.4	**Specific Requirements for Tuberculosis** **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 a Quantiferon. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category.** **This requirement was not met as evidenced by:** Based on interview, record review and review of	3201.6.9.2.4 1.Upon discovery, staff members E20, E21 and E22 were removed from the schedule pending TB Test completion. 2.All residents have the potential to be affected. 3.Human Resources Manager conducted an audit of all of employee files to ensure TB testing is up to date for all employees. For any files found lacking the required TB testing, the employees will be sent for TB testing and	10.24.2024

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	other facility documentation, it was determined that for three (E20, E21 and E22) out of twelve employees sampled for tuberculosis testing the facility lacked evidence of a two-step tuberculin test having been completed. Findings include: 3/5/24 E20 (CNA) was hired. The facility lacked evidence of a first and second step Tuberculin test being completed. 3/5/24 E21 (CNA) was hired. The facility lacked evidence of a first and second step Tuberculin test being completed. 6/8/23 E22 (CNA) was hired. The facility lacked evidence of a first and second step Tuberculin test being completed. 8/7/24 11:00 AM – Findings were confirmed during an interview with E34 (HR). 8/12/24 1:34 PM – Findings were confirmed with E2 (DON) and E3 (ADON). The facility failed to ensure that pre-employment screening was performed for E21, E22, and E23. 8/12/24 2:15 PM – Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	removed from the schedule until this step is completed. Human Resources Manager educated by Administrator on policy that TB testing must be completed and documented in the employee file prior to new employees completing orientation. 4. The HR Director or SDC will audit new hire files weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success with TB Testing. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 10.24.2024	

Provider's Signature *Brian Lenehan* Title NHA Date 10.16.2024

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201.9.0	**Records and Reports**		
3201.9.6	**Reportable incidents shall be communicated immediately, which shall be within eight hours of the occurrence of the incident, to the Division of Long Term Care Residents Protection.**		
3201.9.8	**Reportable incidents are as follows:**		
3201.9.8.4.4	**Significant error or omission in medication/treatment, including drug diversion, which causes the resident discomfort, jeopardizes the resident's health and safety or requires periodic monitoring for up to 48 hours.** **This requirement was not met as evidenced by:** Based on interview and record review, it was determined that for one (R322) out of three residents reviewed for hospitalizations, the faccility failed to report the significant medication error to the State Agency within the required eight (8) hour timeframe. Findings include: Cross refer to F760, example 1 R322's clinical record revealed: 7/6/24 at 3:40 PM – A nurse's note by E44 (House Supervisor) documented that R322 was administered medications that were prescribed for another resident and received a physician's order to transfer to the emergency room for evaluation. 7/6/24 at 4:00 PM – A transfer to hospital summary note by E43 (RN) documented the	3201.9.8.4.4 1.Immediately upon discovery, the medication error was reported. Clinical Management team/IDT Team was educated by Administrator on regulation and policy for timely reporting as well as criteria for reporting medication errors. 2.All residents have the potential to be affected. 3.A lookback audit of medication errors will be conducted by the ADON to ensure timely reporting was completed in instances where required. The lookback period will begin on 6/29/24 and any medication errors requiring reporting will be reported. 4.The DON or Administrative Nurse will audit medication	10.24.2024

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	following individuals were contacted: "… Supervisor… On-call MD and RN, ADON…". 7/8/24 at 4:45 PM – Two days later, the facility reported the 7/6/24 incident to the State Agency according to reporting documentation provided to the Surveyor. 8/12/24 at approximately 10:30 AM – During a combined interview with E1 (NHA), E2 (DON), E3 (ADON) and E10 (VPO), finding was reviewed. E1 stated that the facility management are responsible for reporting incidents to the State Agency, not the House Supervisors. The facility failed to report R322's significant medication error per the State requirement. 8/12/24 at 2:15 PM – Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	errors weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success with reportable medication errors. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5.Date of completion: 10.24.2024	
16 Del. C., Ch. 11, SubChapter II Rights of Residents	**§ 1121. Resident's rights.** **§ 1123. Notice to resident. (a) The Department must prepare a notice that includes § 1121 of this title in its entirety. This notice must be available in a language and format that is accessible to each resident or their authorized representative under § 1122 of this title. (b) Each long-term care facility must post the notice described in subsection (a) of this section conspicuously in a public area of the**		

Provider's Signature *Brian Lenehan* Title NHA Date 10.16.2024

NAME OF FACILITY: Pike Creek Nursing & Rehabilitation Center **DATE SURVEY COMPLETED: September 10, 2024**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	facility. (c) Each long-term care facility must furnish copies of the notice required under subsection (a) of this section to all of the **following: (1) Each resident upon admittance to the facility. (2) All residents currently residing in the facility. (3) Each authorized representative under § 1122 of this title. (d) The long-term care facility must retain in its files a statement signed by each individual listed in subsection (c) of this section that the individual has received a copy of § 1121 of this title. (61 Del. Laws, c. 373, § 2; 81 Del. Laws, c. 206, § 26; 84 Del. Laws, c. 199, § 1.)** **This requirement was not met as evidenced by:** Based on observation, interview and record review, it was determined that the facility has not implemented the Delaware Resident's Rights Act that became effective on 6/27/24. Findings include: 7/3/24 – R322 was admitted to the facility. Review of the resident's record lacked evidence of a signed Delaware Resident Rights Act form. 7/4/24 – R340 was admitted to the facility. Review of the resident's record lacked evidence of a signed Delaware Resident Rights Act form. 8/7/24 from 10:39 AM to 11:00 AM – Observation of all the resident areas in the facility revealed no posting of the Resident's Rights per the new Delaware law effective 6/27/24. 8/7/24 at 11:18 AM – During an interview, E46 (SS) confirmed that she was not aware of this	16 Del. C., Ch. 11. SubChapter II Rights of Residents 1.Upon discovery, Delaware Resident Rights Act form was reviewed with residents R322 and R340. The required postings were posted in the main Lobby of the Center in all languages provided. 2.All residents have the potential to be affected. 3.Admissions Director and Admissions Assistant will review Resident Rights Act form with all current residents and place signed copy in resident file. Social	10.24.2024

Provider's Signature _Brian Lenehan_ Title NHA Date _10.16.2024

NAME OF FACILITY: Pike Creek Nursing & Rehabilitation Center **DATE SURVEY COMPLETED: September 10, 2024**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	new Delaware requirement and at the present time this was not being done in the facility. E46 stated that she provided any new admissions with the Ombudsman's brochure about Resident Rights. 8/7/24 at 11:20 AM – During an interview, the Surveyor reviewed the new Delaware requirement with E1 (NHA). 8/7/24 at 11:45 AM – In response to the interviews, the Surveyor emailed both E46 (SS) and E1 (NHA) the specific information about the new Resident's Rights Act and included attached copies of the English, Haitian Creole, Mandarin and Spanish versions. 8/12/24 at 2:15 PM – Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	Services Staff and Admissions Staff will be educated by Administrator on requirement for reviewing this document with all new residents upon admission. 4.An audit of new residents admitted to the Center will be conducted weekly by Admissions Director to ensure Residents Rights Action form is present and was signed by the resident. Audits will be done weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5.Date of completion: 10.24.2024	

Provider's Signature _Brian Lenehan_ ___Title_______NHA________________Date _10.16.2024______

NAME OF FACILITY: Pike Creek Nursing & Rehabilitation Center DATE SURVEY COMPLETED: September 10, 2024

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
16 Del. C., Ch. 11, SubCh. VII	**§1162 Nursing Staffing:** **(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level re-quired to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement.** **Nursing staff must be distributed in order to meet the following minimum weekly shift ratios:** **RN/LPN CNA*** **Day 1 nurse per 15 res. 1 aide per 8 res.** **Evening 1:23 1:10** **Night 1:40 1:20** *** or RN, LPN, or NAIT serving as a CNA.** **(g) The time period for review and deter-mining compliance with the staffing ratios un-der this chapter shall be one (1) week.** A desk review staffing audit was conducted by the State of Delaware, Division of Health Care Quality, Office of Long Term Care Residents Protection on August 27, 2024. The facility was found to be out of compliance with 16 Delaware Code Chapter 11 Nursing Facilities and Similar Facilities.	 16 Del. C., Ch. 11. SubChapter VII 1.The date specified in 2567 was the only date to fail to meet required PPD. 2.All residents have the potential	10.24.2024

Provider's Signature Brian Lenehan Title NHA Date 10.16.2024

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Based on review of facility documentation it was determined that for one day out of 7 days, the facility failed to provide staffing at a level of at least 3.28 hours of direct care per resident per day (PPD). Findings include: Review of facility staffing worksheets, completed by the Nursing Home Administrator revealed the following: 8/25/2024 PPD = 3.18 8/26/2021 – E1(NHA) submitted an email to the state agency confirming a failure to meet staffing requirements. E1's email documented, "... We may have missed our PPD on 8/25...". The facility failed to maintain the minimum PPD staffing requirement of 3.28. Findings were reviewed with E1 (NHA), E2 (DON) and E10 (VPO) on 8/27/24 beginning at approximately 2:52 PM.	to be affected. 3.Staff Scheduler was educated by Administrator on requirements for daily PPD. Facility utilizes agency staffing, shift pick-up bonuses and overtime pay to fill any gaps in the schedule. 4.An audit of daily PPD will be conducted weekly by the scheduler to ensure PPD minimums are met daily. The results of the audit will be brought to the QAPI Committee for further review and recommendations. 5.Date of completion: 10.24.2024	
16 Del. C., Ch. 11, SubCh. IV	**§ 1141. Criminal background checks.** **(c) An employer may not employ an applicant for work in a facility before obtaining a criminal history. The criminal history of any person not employed directly by the facility must be provided to the facility upon the person's commencement of work.** **This requirement was not met as evidenced by:** Based on interview and review of the State Agency and facility records, it was determined that for one (E80) out of 13 staff reviewed for	16 Del. C., Ch. 11. SubChapter IV 1.At the time of discovery, Staff Member E80 no longer	

NAME OF FACILITY: Pike Creek Nursing & Rehabilitation Center **DATE SURVEY COMPLETED: September 10, 2024**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	background checks, the facility failed to ensure that E80 had a completed criminal background check with the current staffing agency. Findings include: 6/6/24 – E80 (agency CNA) was hired by [name of] staffing agency to work in the facility. 9/4/24 at 3:00 PM – Review of the State Agency's Background Check Center record for E80 revealed that E80's criminal background check was not completed by his current staffing agency. 9/5/24 – Upon request by the Surveyor, the facility provided E80's background check information. An eligibility letter for hire by the State Agency was dated 9/5/24. 9/6/24 at 12:55 PM – The Surveyor confirmed with the State Agency's Background Check Center that E80's criminal background check was completed on 9/5/24. The facility failed to ensure that E80's criminal background check with the current staffing agency was completed prior to working in the facility. 9/10/24 at 2:10 PM – Finding was reviewed with E1 (NHA) during the exit conference.	worked at/with the Center. 2.All residents have the potential to be affected. 3.Human Resources Manager conducted an audit of all of employee files to ensure background check is completed for all employees. For any files found lacking the required background check, the background check will be completed and the employee will be removed from the schedule until this step is completed. Human Resources Manager educated by Administrator on policy that background check must be completed and documented in the employee file prior to new employees completing orientation. 4.The HR Director or SDC will audit new hire files weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success with background checks. The results of these audits will be reviewed with the Quality Assurance and Assessment	10.24.2024

Provider's Signature Brian Lenehan Title NHA Date 10.16.2024

NAME OF FACILITY: Pike Creek Nursing & Rehabilitation Center **DATE SURVEY COMPLETED: September 10, 2024**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5.Date of completion: 10.24.2024	
	§ 1142. Mandatory drug screening. **(a) An employer may not employ an applicant without first obtaining the results of that applicant's mandatory drug screening.** **(d) An agency, including temporary agencies, must provide the drug screening results it receives regarding an applicant referred to work in a facility to that particular facility so that the facility is better able to make an in-formed decision whether to accept the re-ferral.** **This requirement was not met as evidenced by:** Based on interview and review of the State Agency and facility records, it was determined that for one (E80) out of 13 staff reviewed for mandatory drug screening, the facility failed to ensure that E80 had a mandatory drug screening with the current staffing agency. Findings include: 6/6/24 – E80 (agency CNA) was hired by [name of] staffing agency to work in the facility. 9/4/24 at 3:00 PM – Review of the State Agency's Background Check Center record for E80 revealed that E80's mandatory drug	1142 1.At the time of discovery, Staff Member E80 no longer worked at/with the Center. 2.All residents have the potential to be affected. 3.Human Resources Manager conducted an audit of all of employee files – including agency - to ensure drug screening is completed for all	

Provider's Signature _Brian Lenehan_ Title NHA Date _10.16.2024_

NAME OF FACILITY: Pike Creek Nursing & Rehabilitation Center **DATE SURVEY COMPLETED: September 10, 2024**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	screening was not completed by his current staffing agency. 9/5/24 – Upon request by the Surveyor, the facility lacked evidence of E80's mandatory drug screening. 9/10/24 at 2:10 PM – Finding was reviewed with E1 (NHA) during the exit conference.	employees. For any files found lacking the required drug screening, the background check will be completed and the employee will be removed from the schedule until this step is completed. Human Resources Manager educated by Administrator on policy that drug screening must be completed and documented in the employee file prior to new employees completing orientation – including agency staff. 4.The HR Director or SDC will audit new hire files weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success with drug screening. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months.	10.24.2024

Provider's Signature _Brian Lenehan_ ___Title______NHA________________Date _10.16.2024______

NAME OF FACILITY: Pike Creek Nursing & Rehabilitation Center **DATE SURVEY COMPLETED: September 10, 2024**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		5.Date of completion: 10.24.2024	

Provider's Signature __Brian Lenehan ___Title______NHA________________Date _10.16.2024______

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(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 Emergency Preparedness survey was conducted at this facility from July 29, 2024 through September 10, 2024 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census the first day of the survey was 169. 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		
F 000	INITIAL COMMENTS An unannounced Annual, Complaint and Extended survey was conducted at this facility from July 29, 2024 through September 10, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 169. The investigative sample totaled 64 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nursing Assistant; COTA - Certified Occupational Therapy Assistant; CW - Contract Worker; DA - Dietary Aide; DON - Director of Nursing;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/04/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD** **WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 DOR - Director of Rehab; Family Member - FM; LPN - Licensed Practice Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; NP - Nurse Practitioner; OT - Occupational Therapist; Ombudsman - resident representative who investigates reported complaints and helps to achieve agreement between parties; PT - Physical Therapist; RCD- Regional Clinical Director; RN - Registered Nurse; SS - Social Services; SLP - Speech Language Pathologist; SC - Supply Clerk; TA - Transportation Assistant; UM - Unit Manager; VPO - Vice President of Operations; Amputation - Surgical removal of a body part; Auxilliary aids and services - ways to communicate with residents who have communication disabilities; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15. 13-15: Cognitively intact. 8-12: Moderately impaired. 0-7: Severe impairment. Crotch - in humans, the place where the legs meet together and join the body; eMAR - Electronic Medical Administration Record; EMS - emergency medical services; ER - emergency room; Eschar - tan, brown, or black sometimes hardened dead tissue found on pressure ulcers; esophagus - hollow, muscular tube that carries	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ___ B. WING ___	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 2 food and liquid from your throat to your stomach; gm - gram/unit of weight; Grope - to touch or fondle someone's body for sexual pleasure, especially without their consent; ICU - Intensive Care Unit; Kardex - Form that instructs the CNA on care and interventions needed for each particular resident; LEP (Limited English Proficiency) - not fluent in the English language; Medication Administration Record (MAR) - list of daily medications to be administered; Medication Regimen Review (MRR) - monthly review by pharmacist of resident's medications, laboratory tests and any records necessary to determine whether or not irregularities exist; mg - milligram/unit of weight; Occupational therapy - form of therapy for those recuperating from physical or mental illness that encourages rehabilitation through the performance of activities required in daily life; mg (milligrams) -unit of weight, 1 mg equals 0.0035 ounce; mL (milliliters) -unit of liquid volume, 5 ml equals 1 teaspoon; MDS (Minimum Data Set) - standardized assessment forms used in nursing homes; PU - Pressure Ulcer - sore area of skin that develops when blood supply is cut off due to pressure; PRN - As needed; Slough - yellow, tan, gray, green or brown soft tissue present on pressure ulcers; Stage III (3) - pressure ulcer that goes into the tissue under below the skin; Unstageable - pressure ulcer which the depth can not be determined due to the presence of slough and/or eschar. 2567 - Statement of deficiency's Report generated from identified deficient practice during	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 3 the survey;	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be	F 550		11/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ________ B. WING ________	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4 free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for one (R422) out of two residents reviewed for dignity, the facility failed to ensure that the urinary collection container was placed in a privacy bag. Findings include: Review of R422's clinical records revealed: 1/14/24 - R422 was admitted to the facility with diagnoses including obstructive uropathy and bladder dysfunction. 1/30/24 - R422 clinical records included, "Catheter care every shift, and as needed." 6/26/24 - R422's quarterly MDS assessment documented a BIMS score of 00, indicating severe cognitive impairment. R422 required total assistance from staff with all activities of daily living. 7/16/24 - R422's care plan included, "Maintain catheter privacy bag." 7/30/24 9:10 AM - R422 was observed lying in his bed, an uncovered/undated urinary collection bag was visably observed from the door on the floor on the right side of the bed. 7/30/24 10:15 AM - R422 was observed lying in his bed, an uncovered/undated urinary collection	F 550	F-550 1. Upon discovery, R422□s catheter bag was placed in a privacy/dignity bag. 2. All residents utilizing urinary catheters have the potential to be affected. Residents with urinary catheters were reviewed to ensure all residents have dignity/privacy bags present in their rooms and facility has sufficient supply in Central Supply. 3. Nursing staff will be educated by the Staff Development Coordinator or designee on resident rights/dignity and on the use of privacy/dignity bags for catheters. Managers will be trained by Administrator on reviewing for this practice while making Facility Rounds. Root cause identified as lack of following requirements and supervisor rounding. 4. The Director of nursing or administrative nurse will audit residents with urinary catheters weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11.11.2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 5 bag was visibly observed from the door on the floor on the right side of the bed. 7/30/24 12:15 PM - R422 was observed lying in his bed, an uncovered/undated urinary collection bag was visibly observed from the door on the floor on the right side of the bed. 7/30/24 12:30 PM - A review of R422's clinical records lacked evidence of documentation of a privacy bag. 7/30/34 12:45 PM - Findings were confirmed with E2 (DON). The facility failed to maintain R422's privacy and dignity by ensuring that the urinary collection container was placed in a privacy bag. 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 550		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.	F 552		11/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 552	Continued From page 6 §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility documentation as indicated, it was determined that for one (R324) out of four residents reviewed for falls, the facility failed to inform R324's representative/POA (Power of Attorney) of a fall. Findings include: Cross refer to F689, example 1 R324's clinical record revealed: 6/22/24 at 6:00 AM - The facility's incident report lacked evidence that F7 (R324's representative/POA) was notified of the fall. 7/6/24 - The facility's investigation of the 6/22/24 incident revealed a documented telephone statement from E43 (RN) that included, "... Her [F7, representative/POA] was super involved every day." 7/31/24 at 7:30 PM - During an interview, F7 (R324's representative/POA) stated that R324 called him around 8:00 AM on 6/22/24 and told him that she fell during a transfer. F7 stated that the facility never informed him about the fall. 8/6/24 at 12:25 PM - During an interview, E52 (RN/House Supervisor) stated that E43 (RN), the assigned nurse, was to notify the doctor and the family of the incident. E52 stated that she did not	F 552	F-552 1. As stated in 2567, R324□s responsible party was contacted prior to survey and notification was documented. 2. All residents experiencing falls have the potential to be affected. A lookback audit of falls starting 8/16/24 was conducted by the RDCS to ensure all falls were compliant with responsible party/physician notification requirements. 3. Licensed Nurses will be educated by the Staff Development Coordinator or designee on policy and procedure for responsible party/physician notification after a resident falls. Root cause identified as supervisor follow-up. 4. The Director of nursing or administrative nurse will audit falls weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11.11.2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 552	Continued From page 7 know if the family member was notified. 8/12/24 at 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 552		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or	F 580		11/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 580 Continued From page 8

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of facility documentation as indicated, it was determined that for one (R340) out of two residents reviewed for death, the facility failed to consult with R340's physician of her repeated refusals of two medications. Findings include:

R340's clinical record revealed:

7/24/24 - R340 was admitted to the facility with diagnoses that included, but were not limited to, chronic obstructive pulmonary disease (COPD/inflammatory lung disease), asthma and acute and chronic respiratory failure with hypoxia (insufficient oxygen in the blood).

7/24/24 - A physician ordered Breo Ellipta inhaler daily for shortness of breath and Spiriva inhaler daily for COPD.

F 580

F-580
1. Upon discovery, R340□s physician was contacted to inform him/her of the breo and spiriva refusal.
2. All residents taking breo and spiriva have the potential to be affected. A 30-day lookback audit of breo and spiriva refusals will be conducted by the DON to ensure all refusals were compliant with physician notification requirements.
3. Licensed Nurses will be educated by the Staff Development Coordinator or designee on policy and procedure for physician notification after a resident refuses breo and spiriva. Root cause identified as supervisor follow-up and staff education.
4. The Director of nursing or administrative nurse will audit breo and spiriva refusals weekly x 4 weeks until

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 9 Review of the July 2024 eMAR revealed that five out of seven days, R340 refused both her Breo and Spiriva medications. Review of the August 2024 eMAR revealed that four out of six days, R340 refused both her Breo and Spiriva medications. There was no evidence that the physician nor R340's resident representative were notified that R340 was repeatedly refusing these medications per the plan of care. 8/9/24 at 1:40 PM - During an interview, E18 (LPN/UM) stated that she was not aware that R340 was refusing the Breo and Spiriva medications. 8/9/24 at 2:21 PM - During an interview, E38 (RN) stated that he does not recall notifying the doctor that R340 was refusing those medications. 8/12/24 at 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 580	100% consecutively and then monthly x 3 months until facility reaches 100% success with notification process. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11.11.2024	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC	F 585		11/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 10 facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 11 conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 12 result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R323 and R423) out of two residents reviewed for grievances, the facility failed to ensure that concerns for missing dentures and a fall were resolved in a timely manner. Findings include: A facility policy and procedure, dated 1/23/20, and titled, "Service Concerns" documented, " ...Staff are trained appropriately in resolving ... patient/family concerns ...as promptly as possible... 3. The department manager receiving the company Service Concern Report actively and promptly initiates appropriate action (no later than 48 hours of receiving the concern). The department manager will follow up with the patient/family to determine satisfaction and will complete in full, the Step II Department Manager Response section on the yellow copy of the form and forward it immediately to the Administrator. 4. The Administrator will follow up as needed with the patient/family regarding satisfactory resolution and will verify the final outcome on the form. He/she will complete the Step III Disposition by Administrator section of the company Service Concern Report on his/her white copy of the form...". 1. Review of R423's medical records revealed: 10/23/23 9:00 PM - R423 was admitted to the facility with diagnoses including difficulty swallowing and dementia. R423's admission nursing assessment documented, "some or all	F 585	F-585 1. Upon discovery, Center responded to R423□s and R323□s grievances to each resident/family□s satisfaction. 2. All residents have the potential to be affected. 3. Grievance policy and procedure updated so the grievance log/binder is brought daily to Morning Standup and Afternoon Standdown Meetings. New grievances are discussed and logged and assigned to the appropriate department for resolution along with a 3-business-day deadline to determine a resolution with a final deadline of 5-business days to inform the party filing the grievance of the resolution and/or the plan to resolve the grievance. Once resolved, grievances will be logged as complete and filed in a separate section of the binder. Social Services Team educated by Administrator on new policy. A 30-day lookback audit will be conducted by the Social Services Director of existing grievances to ensure all are resolved to the grievance filer□s satisfaction and these grievances are logged and filed accordingly. Root cause identified as grievance policy and procedure being ineffective so plan above will be implemented. 4. The Administrator will audit grievances weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100%	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 13 natural teeth ...no dentures." 10/24/23 11:10 AM - R423's discharge planning record documented, "Patient has dentures." 10/24/23 - A facility document titled, "Concern Form" documented, "Family notified staff her dentures are missing." The scheduled resolution date for the concern was 10/26/23. 8/8/24 11:00 AM - During a telephone interview, F1 stated, "My mother (R423) was admitted to the facility with both upper and lower dentures. The next day the facility informed me that they were missing. They (the facility) told me that the dentist had already been there for the month, and I can take my mother to her own dentist to have replacement dentures made. The facility will pay for it. I gave them the bill for $4,700 on 12/7/23, and I keep getting the run around when I try to find out when I am going to get the money back." 8/8/24 12:00 PM - During an interview, E1 (NHA) stated, "We have contacted the office about the payment for the dentures." 8/8/24 2:30 PM - E1 provided a copy of a check dated 8/8/24 for $4,700 and stated that it will be mailed out today to R423. 8/8/24 3:00 PM - During a telephone interview, F1 stated that she was informed by E1 that the reimbursement check will be sent out today. The facility failed to resolve R423's concerns for the missing dentures for a total of 8 (eight) months. 2. R323's clinical record revealed:	F 585	success with. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11.11.2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 14	F 585		

11/2/23 - A progress note by E6 (NP) documented that R323 fell on the right side and complained of pain. An x-ray of the right hip redemonstrated acute fracture of right femoral neck (hip joint) which was one of the admitting diagnoses.

1/10/24 - During a care conference, a concern form was completed by E46 (SS/Social Services) which stated that R323 and a family member were asking about the fall incident and they wanted a copy of the incident report. Under Section II, the following individuals' titles were listed as designated to take action on this concern: Therapy, SS, Unit Manager, NHA. The concern form's date of resolution was 1/15/24. The results of action taken under Section II was documented as "staff met with patient and family and updates were given. NHA declined to give copy of incident document since internal document." Under Section III, the resolution of R323's concern was check "No, family still wanted incident report copy." It was unclear what updates were given by each individual designated to take action on this concern form and which staff person had a one-to-one discussion with the resident on 1/15/24. In addition, the former NHA did not sign and date that R323's concern form was reviewed and verified as per the facility's policy.

8/1/24 at 1:28 PM - During an interview, R323 stated that she was transferring from wheelchair to bed and she thought the CNA was still there. R323 stated that she went to stand up as she normally does and the CNA had moved the wheelchair and I fell real hard on my right side. R323 stated that she was recovering from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 15 multiple fractures from a motor vehicle collision. The CNA was trying to pull me up off the floor. I said you can't do that because of my fractures/injuries. 8/8/24 at 10:14 AM - During an interview, E13 (Rehab Director) stated that if a resident falls, the policy was to lift the resident off the floor with a hoyer lift. It was unclear in R323's concern form that this was addressed with R323. The facility failed to complete R323's service concern dated 1/10/24 about her fall. 8/12/24 at 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 585		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was	F 600	In response to the facility implementing	11/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 600

Continued From page 16

determined that for one (R109) out of three residents reviewed for abuse, the facility failed to ensure that R109 was protected from verbal and emotional abuse when a staff member accused him of stealing chips that were left over from a staff party. Findings include:

Review of R109's clinical records revealed:

9/26/23 - R109 was admitted to the facility with diagnoses including cerebral palsy and bipolar disorder.

4/25/24 8:30 AM - A facility incident report submitted to the State Agency documented, "[R109] reported that a facility employee [E11] called him a "thief" because he took some chips that were left over from a staff party earlier in the day."

In response to R109's 4/25/24 incident, the facility implemented the following corrections:

- From 4/25/24 to 5/16/24, the facility's training attendance sheet, titled, "Abuse and Neglect", documented that nursing, dietary, administrative and housekeeping staff recieved training in response to this incident.

7/8/24 - R109's quarterly MDS assessment documented a BIMS score of 14, indicating a cognitively intact status.

8/2/24 10:49 AM - During an interview, R109 stated, "I took some chips for a friend and me because we were told that we can have the leftovers. [E11] called me a thief and took the chips away. I tried to explain that I did not steal the chips, but he kept on insisting that I was a

F 600

corrections and no further incidents of abuse that were identified during the Survey, R109's incident was past non-compliance.

8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 17 thief. I was very upset because I did not like to be called a thief." 8/2/24 12:00 PM - A review of the facility's investigation revealed that E11's accusations were witnessed by several staff members and residents. The facility substantiated R109's allegation of verbal and emotional abuse from E11. E11 was terminated from employment at the facility. The facility failed to protect R109 from verbal and emotional abuse. In response to the facility implementing corrections and no further incidents of abuse that were identified during the Survey, R109's incident was past non-compliance. 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 600		
F 609 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	F 609		11/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 18 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 review of clinical records and other documentation as indicated, it was determined that for two (R176 and R344) out of seventeen (17) residents reviewed for abuse, the facility failed to report alleged violations involving abuse no later than 2 hours after each allegation was made. Findings include: 1. 8/30/24 at 6:08 PM - Review of State Agency's incident intake revealed that the facility reported an allegation of abuse involving R175. 8/30/24 from 4:30 PM to 6:00 PM - The facility's investigation of R175's allegation documented that E46 (SW) interviewed other residents, which included R176. 9/3/24 at 5:30 PM - Review of the State Agency's incident intake revealed that the facility reported an allegation of abuse involving R176. 9/10/24 at 8:32 AM - During an interview, E46	F 609	F-609 1. As noted in 2567, report was filed for both residents prior to Survey. 2. All residents have the potential to be affected. 3. Education on Abuse and Neglect including 2-hour reporting window and on all staff□s role as mandatory reporters was conducted by Staff Development Coordinator/designee for nursing and non-nursing staff. Random audits with staff of their knowledge of abuse and neglect were conducted by facility managers. Root cause identified as employees needing to understand role as mandatory reporters and need to report items to supervisor even if resident states they already reported it. This was covered in above education and audits. 4. The Administrator will audit abuse reports weekly x 4 weeks until 100% consecutively and then monthly x 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 609 Continued From page 19

(SW) confirmed that R176 hand wrote a statement. E46 collected the statement along with other residents' signed statements and handed all the statements to E59 (DON 2) on 8/30/24.

9/10/24 at 8:36 AM - During an interview, E59 confirmed that she received a stack of statements from E46 on Friday, 8/30/24, but she did not know about R176's allegation of abuse that was in her written statement. E59 stated that the paperwork was placed in a red file folder. R176's written statement was not seen until Tuesday, 9/3/24. E59 confirmed that R176's allegation of abuse was not reported within the required 2 hour timeframe.

2. 8/7/24 1:18 PM - The facility reported to the State Agency an allegation of sexual abuse involving R344 and R172.

8/15/24 - The facility's follow up summary submitted to the State Agency documented:
- "...[R344] stated that this occurred on Sunday night 8/4/24 (going into Monday morning 8/5/24)...
- ...[R344] stated that he had reported this to only a CNA and Therapy...
- ... Per [E77 (CNA)] witness statement, [R344] reported to her on Monday, Aug 5th (8/5/24), that his roommate [R172] was wandering on his side of the room, but [E77] (sic) stated [R344] did not report that [R172] had touched him...
- ... Per statement from [E78 (Physical Therapist)], [R344] reported to her on Tuesday 8/6/24 that [R172] had come over and grabbed his crotch, [R344] said it happened at night, (sic) [E78] had asked [R344] if he had reported it and [R344] had said yes, (sic) [E78] did not report it further as she thought it had been...
- ...Per statement from [E79 (COTA)], she worked

F 609 (Provider's plan of correction)

months until facility reaches 100% success. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months.

5. Date of completion: 11.11.2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609		F 609		

Continued From page 20
with [R344] on Wednesday 8/7/24 and told her that [R172] had touched him in his private area...his penis, and reported it to...[E13 (DOR)] who in turn reported it immediately to E1 (NHA) and E2 (DON) on Wednesday 8/7/24 at approximately 11:00 AM..."

9/6/24 9:21 AM - In an interview, E77 stated "... [R344] was alert and oriented and he was on my assignment on that day shift. He did not tell me about his roommate [R172] groping his private area. He told me that [R172] was wandering on his [R344] side of the room looking for the bathroom. At no time do I recall him saying that [R172] groped him. Had he told me about it that he was groped, I would definitely report it to the nurse."

9/6/24 10:40 AM - During an interview, R344 stated that roommate [R172] walked to his side of the bed and grabbed his crotch. R344 stated "...I did report it to the aid the following morning. I also talked to therapy about it. I don't know the staff names."

9/6/24 1:11 PM - In an interview, E13 confirmed that E78 did not take any further action in reporting R344's concerns to the management when R344 reported the allegation to E78 on 8/6/24. E13 stated that E78 was not familiar with the abuse mandatory reporting requirement.

9/9/24 10:30 AM - During an interview, E79 stated that R344 reported to him about his roommate [R172] groping his crotch one night - on a weekend. E79 also confirmed that she immediately reported R344's allegations to E13.

9/10/24 10:40 AM - In an interview, E78 stated

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 21 that on that morning around breakfast time (8/6/24), R344 stated that his roommate was getting up and walking around to his side of the bed and "grabbed his crotch.". E78 further stated, "I asked him if he [R344] reported it. [R344] said he already told nursing about it. I didn't ask details from [R344] regarding the incident. I just told him that it's not appropriate and that it should not happen. I made the mistake of not reporting it immediately to my DOR [E13]." The facility failed to identify and immediately report R344's allegation of sexual abuse by R172 on 8/6/24 around breakfast time. The facility reported the allegation of sexual abuse to the state agency after more than 24 hours on 8/7/24 at 1:18 PM. 9/10/23 2:10 PM - Findings were reviewed with E1 (NHA).	F 609		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		11/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 22 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for six (R90, R111, R118, R165, R170 and R31) out of six residents reviewed for care plans, the facility failed to develop and implement a comprehensive person-centered care plan. For R90, R111, R118, R165 and R170, the facility failed to develop care plans based on assessmnet to restore and	F 656	F656 1. For R90, a 3 day voiding dairy to determine continence status was completed. For R111 a 3 day voiding diary was completed to determine continence status. For R118 a 3 day voiding diary to determine continence status was completed. R165 no longer resides at the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 656 Continued From page 23
maintain their bladder and bladder continence to the extent possible. For R31, the faciliy failed to develop a care plan to address R31's right hand contracture and use of the right hand palm guard. Findings include:

Cross refer F690 and F880.

1. Review of R90's clinical revealed:

6/15/24 - R90 was admitted to the facility with diagnoses including heart disease and high blood pressure.

6/15/24 - R90's admission nursing assessment documented, "Continent of bladder, continent of bowel."

6/15/24 - R90's toileting care plan documented, "The resident (R90) is incontinent of bladder and bowel." The interventions included, "Provide toileting hygiene."

6/26/24 - R90's admission MDS assessment documented, "Occasionally incontinent of bladder, occasionally incontinent of bowel. Partial to moderate assist to get on and off the toilet." R90's MDS assessment documented a BIMS of 15, indicating a cognitively intact mental status.

8/2/24 9:00 AM - R90's Kardex (electronic information for the CNAs) documented, "One-person limited assist for transfers."

R90's Kardex lacked a care plan to promote bowel and bladder continence.

8/6/24 10:00 AM - A review of R90"s clinical records from 7/8/24 to 8/6/24 revealed 64

F 656 (Plan of Correction)
facility. For R170 a 3 day voiding diary was completed to determine continence status. For R31, the Care plan was updated. All diaries and status-updates were care planed for these residents.
2. All residents have the potential to be affected. The Director of Nursing/designee will audit residents care plans of residents with bladder diaries and/or contractures and/or adaptive equipment to ensure it is included in their person-centered care plan. Any missing will be corrected upon discovery.
3. DON/designee will educate nursing staff on creating resident centered care plans and three-day-voiding diaries. The root cause identified as staff education for developing, revising and updating person-centered care plans.
4. The Director of nursing or administrative nurse will audit 5 residents care plans to verify accuracy of continence care plans weekly x4 until facility reaches 100% consecutively and then 5 residents monthly for 3 consecutive months until facility reaches 100% success. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months

5. Date of completion: 11.11.2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 656 Continued From page 24 F 656

episodes of urinary incontinence, and 2 episodes of bowel incontinence. R90's clinical records lacked evidence of a bowel and bladder assessment and a personalized plan of care to promote bladder and bowel continence.

2. Review of R111's clinical records revealed:

7/1/24 - R111 was admitted to the facility with diagnoses including urinary tract infection, acute pyelonephritis (kidney infection) and kidney stones.

7/1/24 - R111's toileting care plan documented, "Incontinent of bladder and/or bowels."

7/11/24 - R111's admission MDS assessment documented a BIMS of 12, indicating a moderate cognitive impairment, and the urinary assessment documented, "Occasionally incontinent of urine..."

8/6/24 11:00 AM - During an interview, R111 stated, "I use to the toilet to pee, and have a bowel movement." R111 was observed to be wearing an incontinence brief.

8/6/24 1:04 PM - A review of R111's clinical records from 7/8/24 to 8/5/24 revealed 11 episodes of urinary incontinence.

8/6/24 1:30 PM - A review of R111's clinical records lacked evidence of a bladder and bowel assessment, and a personized toileting care plan.

3. Review of R118's clinical records revealed:

3/8/23 - R118 was admitted to the facility with diagnoses including high blood pressure and diabetes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 25	F 656		

3/8/23 - R118's admission toileting care plan documented, "Frequently incontinent of bladder and bowels and is not a candidate for a toileting program due to inability to control bowel and bladder." The interventions included, "Provide toileting hygiene."

6/18/24 - R118's quarterly MDS assessment documented a BIMS score of 15, indicating an intact cognitive status. R118's clinical records documented that supervision/touching from staff is required to get on or the toilet, and "Always incontinent of bladder, frequently incontinent of bowel."

8/5/24 10:00 AM - During an interview, R118 stated, "I can stand to use the bathroom, but no one ever offers me to go to the toilet."

4. Review of R165's clinical records revealed:

7/6/24 - R165 was admitted to the facility with diagnoses including a fracture of the right knee and high blood pressure.

7/6/24 - R165's nursing admission assessment documented, "Incontinent of bladder, incontinent of bladder." R165's care plan documented, " ...Is incontinent of bladder and/or bowels... provide toileting hygiene."

7/17/24 - R165's admission MDS documented a BIMS score of 10, indicating moderative cognitive impairment. The MDS documentation included, "Frequently incontinent of bowel and bladder."

8/5/24 1:34 PM - During an interview, R165 stated, "I don't know what I am doing here, I put

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 26 my call bell on and wait a long time for someone to come and take care of me. I have never been to the toilet since I got here. I must go on myself. It's not good, I am very angry about it." 8/5/24 11:30 AM - During an interview, E29 (CNA) stated, "I change her (R165) in bed, and she is always incontinent." 5. Review of R170's clinical records revealed: 7/17/24 - R170 was admitted to the facility with diagnoses including muscle weakness, urinary tract infection, and urinary retention. 7/17/24 - R170's nursing admission assessment documented, "Incontinent of urine and bowel." 7/17/24 - R170's toileting care plan documented, "The resident is incontinent of bladder and/or bowels, provide toileting hygiene. " 7/29/24 - R170's admission MDS assessment documented a BIMS of 14, indicating a cognitive intact status. The MDS also documented, "Frequently incontinent of urine, always incontinent of bowel." 8/5/24 1:10 PM - During an interview, R170 stated, "I try to use the urinal, but it does not always work, I used to sit on the toilet at home." 8/5/24 1:30 PM - During an interview, E35 (CNA) stated "I don't know if he (R170) can use the toilet. I change him in bed when he is wet." 8/5/24 2:00 PM - During an interview E18 (UM) stated "We do a 3-day voiding diary on admission." A review of R170's clinical records	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 27	F 656		

lacked evidence that a 3-day voiding diary was done.

8/5/24 2:30 PM - A review of R170's clinical records from 7/18/24 to 8/4/24 revealed 29 episodes of urinary incontinence, and 19 episodes of bowel incontinence.

The facility failed to formulate person centered care toileting care plans with interventions to promote continency for R90, R111, R118, R165 and R170.
6. Review of R31's clinical records revealed:

5/31/23 - A facility OT Treatment Encounter Note documented, " Patient performed passive ROM of Patient's R (right) hand and applied palm guard which she is tolerating...educated her on plan of care to use palm guard for comfort."

6/7/23 - An OT (Occupational Therapy) Discharge Summary documented, "Discharge Recommendations: R hand palm guard.

8/1/24 11:45 AM - In an interview, E2 (DON) stated that she is aware that R31 has a right hand contracture. E2 further confirmed that R31 did not have a care plan for right hand contractures.

The facility failed to develop a person - centered care plan with interventions to address R31's right hand contracture.

8/7/24 5:30 PM - Findings were discussed with E1 (NHA), E2 (DON), E3 (ADON) and E10 (VPO).

8/12/24 at 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 28 and a State of DE Ombudsman (via telephone).	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R320) out of four residents reviewed for accidents and one (R31) out of one resident reviewed for care planning, the faciliy failed to review and revise the	F 657	F-657 1. Upon discovery, R320□s care plan was updated to include the use of a urinal. R31□s Care Plan was updated to include PROM.	11/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 29 residents' care plans. Findings include: 1. R320's clinical record revealed: 5/30/24 - R320 was admitted to the facility with a primary diagnosis of a urinary tract infection. 5/30/24 - R320 was care planned for incontinent of bladder and bowel with the following two approaches: - record bowel movements; and - refer to occupational therapy as indicated. 7/22/24 - In response to an incident that occurred on 7/2/24 at 7:30 AM, E3 (ADON) interviewed R320, who stated stated that he was reaching for his urinal and getting ready to use it at the same time and was probably too close to the edge of the bed and slid down. The facility failed to ensure R320's incontinence care plan was person centered and included the use of a urinal. 8/8/24 at approx. 3:45 PM - Finding was reviewed with E1 (NHA), E2 (DON) and (E3) ADON. No further information was provided. 2. Review of R31's clinical records revealed: 1/18/24 - R31 was care planned to require assistance with ADLs and interventions included but not limited to Restorative Nursing Program Passive Range of Motion - provide Passive Range of Motion to bilateral lower extremities BID (two times a day) and PRN (when needed) as tolerated. 3/11/24 - R31's careplan intervention on	F 657	2. All residents requiring use of urinal and all residents with a PROM Program have the potential to be affected. 3. A 30-day lookback audit will be conducted of residents who experienced a change in incontinence interventions and/or change in or new PROM program. The audit will be conducted to determine if their care plans were updated. Licensed nurses will be educated on updating care plans by SDC or designee. Root cause identified as staff education needed and supervisor follow-up. 4. The Director of nursing or administrative nurse will audit residents with updates to incontinence interventions and/or change in PROM program weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success with updating care plans. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11.11.2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 30	F 657		

Restorative Nursing Program Passive Range of Motion - provide Passive Range of Motion to bilateral lower extremities BID had no order to cancel.

A review of R31's physician orders lacked evidence that R31's Passive Range of Motion to bilateral lower extremities BID was canceled or discontinued.

8/1/24 10:48 AM - E2 (DON) stated that she did not know how the care plan intervention on R31's PROM was canceled by the (elctronic health record) system. In addition, E2 stated, "It's possible that [R31's] care plan intervention came off in the system when she was sent to the hospital and it was not reviewed when she was re-admitted earlier this year."

8/1/24 1:10 PM - During an interview, E13 (DOR) confirmed that R31 was referred to restorative nursing for passive rage of motion. E13 further stated, "[R31's] intervention for Passive Range of Motion to bilateral lower extremities BID should have stayed current in R31's care plan."

The facility failed to review and update the ADL care plan intervention of PROM which was initiated on 1/18/24 for bilateral lower extremity contractures and was canceled by the system on 3/11/24.

8/7/24 5:30 PM - Findings were discussed with E1 (NHA), E2 (DON), E3 (ADON) and E10 (VPO).

8/12/24 at 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility documentation as indicated, it was determined that for two (R94 and R31) out of seven residents reviewed for activities of daily living (ADLs), the facility failed to ensure each dependent resident received the necessary services to maintain grooming and personal hygiene. Findings include: 1. R94's clinical record revealed: 12/22/23 - R94 was care planned for incontinence of bladder and/or bowels: inability to control bowel and bladder. Approaches included: - 1 person assist with toileting; - check and change briefs frequently as needed; and - refer to occupational therapy (OT) as indicated. 7/2/24 - Review of the July 2024 CNA Documentation Survey Report revealed the absence of documentation of R94's care from 7 AM through 3 PM. In addition, R94's meal intakes (breakfast and lunch) were not documented too. 7/2/24 at 9:11 PM - The facility reported the following incident to the State Agency: "On 7/2/24 at approx. 4:40 PM, [R94] (BIMS 13 [cognitively intact] - dependent on staff for care) reported to the nurse that he did not receive care on the previous shift. Observed in bed, his	F 677	F-677 1. Deficient Practices cited in 2567 are from a Facility Self-Reported-incident from prior to Survey. As stated, resident R94 stated there have been no further issues. As stated, R31 was provided care on the following shift. 2. All residents have the potential to be affected. 3. Licensed Nurses and CNA□s will be educated on providing ADL Care by SDC or designee. Unit Managers and Supervisors will be educated on purposeful rounding by the DON and on their role in holding staff accountable for ADL completion. New Rounds Sheets will be developed and provided to team by RDCS. Unit Managers will complete rounds on 100% of residents M-F and Weekend Supervisors will complete rounds on 100% of residents Saturday and Sunday to ensure ADL□s are being completed. Rounds sheets will be submitted to the DON daily for review. Root cause identified as supervisor rounding. 4. The Director of nursing or administrative nurse will audit Supervisor Rounds Sheets weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100%	11/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 677 Continued From page 32
clothing and bedding soiled with urine and feces. Incontinence care was provided, skin was assessed and noted with redness to his peri-area. Zinc oxide applied. NP and resident representative were notified. The accused CNA, an employee of the facility, was suspended pending investigation."

7/2/24 at 10:32 PM - A nursing note documented that R94 was "noted with MASD (moisture associated skin damage) on his sacrum, NP notified, ordered to wash resident with soap and water, then apply zinc oxide. Family notified."

8/7/24 at 9:50 AM - The Surveyor submitted a written request for the facility's incident report, entire investigation and the corrective actions taken. In response, the facility stated in their investigation that staff education was provided and audits were started on 7/3/24. The facility provided documented evidence that the CNA was terminated on 7/9/24.

8/8/24 at 12:37 PM - During an interview, R94 confirmed that hygiene/toileting care was not provided at all on day shift (7/2). R94 stated that when the 3 PM shift came in, the CNA apologized for no care being provided. R94 stated that he hit his call bell numerous times, but no one responded to him. The Surveyor observed and confirmed with the resident that he clips his call bell to the bed control and to the linens so it doesn't fall on the floor so he was able to access it. R94 stated that he doesn't remember who the CNA was that day. R94 stated that different staff person brought his meals (breakfast/lunch) into his room and he remembered mentioning it to the staff person when his lunch was brought in that he hadn't received any care yet. When asked how

F 677
success with ADL Care on Supervisor Rounds Sheets. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months.

5. Date of completion: 11.11.2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 33	F 677		

did he feel that day about not receiving care or the call light not being answered, he stated he was "irritated." He also added that he "understands that he might have to wait because the aides are busy but all day?" He appreciated the follow-up. R94 stated that the Social Worker came in after this incident and spoke to him. When asked if there have been more incidents of this nature since this incident on 7/2/24, he stated no.

As of 8/12/24, the facility provided no evidence of corrective actions taken with respect to this incident in response to the Surveyor's written request on 8/7/24.

The facility failed to ensure R94, a dependent resident, received hygiene/toileting care on 7/2/24 day shift. Care was not provided to R94 until the 3-11 PM shift.

2. Review of R31's clinical record revealed:

5/12/23 - R31 was admitted to the facility with diagnoses including but not limited to stroke and hemiplegia (half of body paralyzed).

1/18/24 - R31 had a care plan for a toileting deficit related to bowel and bladder incontinence with the goal for R31 to remain as clean and dry as possible. Interventions included:
- check and change briefs frequently as needed;
- provide toileting hygiene with brief changes; and
- refer to OT (Occupational Therapy) as indicated.

7/2/24 - A review of the July 2024 CNA Documentation Survey Report revealed the absence of documentation of R31's care from 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 34	F 677		

AM through 3 PM. In addition, R31's meal intakes (breakfast and lunch) were not documented.

7/2/24 9:23 PM - The facility reported the following incident to the State Agency:
"On 7/2/24, at approximately 4:30 pm the C.N.A. assigned to provide care on the 3-11 shift, to resident, [R31], reported to the nurse that the resident, BIMs=2 (cognitively impaired) and dependent on staff for care, was observed incontinent of urine, with her clothing and bed linens wet with urine and what appeared to be dried areas of urine. Incontinence care was provided when the resident was observed and a skin assessment was completed, the resident did have previous existing moisture associated skin damage to her sacral area, it did appear to have increased redness from the assessment on wound rounds on 7/1/2024. Treatment in place, Zinc Oxide, and applied per orders. The NP and resident representative were notified. The accused C.N.A., (E21), an employee of the facility, was suspended pending investigation. Investigation is in progress."

7/2/24 at 10:38 PM - A nursing note documented that R31 was "noted with MASD (moisture associated skin damage) on her sacrum, NP notified, ordered to wash resident with soap and water, then apply zinc oxide. Family notified."

7/2/24 - A facility incident/investigation report revealed that E2 (DON) conducted a telephone interview with E21. Further review of the report revealed that E21 did not provide patient care within the times she was assigned to provide care to R31.

8/1/24 10:45 AM - In an interview, E42 (LPN)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 35 stated that on 7/2/24, the 3-11 PM CNA reported to him that [R31] was soiled and the bed linen was dirty with dried areas of urine. E42 further stated that he and the 3-11 PM CNA changed R31's soiled incontinence briefs, gown and bed linens. The facility failed to ensure R31, a dependent resident, received hygiene/toileting care on the 7/2/24 day shift. Care was not provided to R1 until the 3-11 PM shift. 8/7/24 5:30 PM - Findings were discussed with E1 (NHA), E2 (DON), E3 (ADON) and E10 (VPO). 8/12/24 at 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		11/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 36 Based on observation and interview it was determined that for one (R129) out of two residents reviewed for pressure ulcers the facility failed to promote of healing of pressure ulcers when pressure ulcer prevention interventions were observed not in place. Findings include: The facility policy on wounds/skin impairments last updated 7/17/24 indicated, "All mattress or devices will be pressure relieving. Provide treatments as ordered." Review of R129's clinical record revealed: 10/2/23 - R129 was admitted to the facility with multiple diagnoses including history of a traumatic brain injury, with severe bleeding to the brain, convulsions, and muscle weakness. 10/2/23 - A care plan was created for risk for pressure ulcers and skin breakdown that included interventions to assess the skin for breakdown, keep the skin clean and dry, pressure relieving mattress, pressure relieving chair cushions and skin assessments as indicated. 10/9/23 - A Braden scale skin assessment documented that R129 was very high risk for pressure ulcer development. 12/5/23 - A wound care assessment documented that R129 acquired an abrasion to the right ear. 1/12/24 - R129's care plan for risk for additional pressure ulcers and skin breakdown was updated to include an intervention to use an adaptive pillow to be positioned on the right side of head at all times. Make sure the ear is inside the center cut out and not on the pillow.	F 686	F-686 1. Upon discovery, resident□s R129 care plan was updated to reflect current needs and new equipment was ordered. 2. All residents with pressure ulcers have the potential to be affected. 3. Staff development coordinator will educate nursing staff on reviewing Resident Kardex before providing care and ensuring any and all equipment listed in the Kardex is present for the resident particularly as related to pressure ulcers. Wound nurse will conduct an audit of Resident Kardexes of residents with pressure ulcers to ensure all interventions are noted in the Kardex. From there, Wound Nurse and Unit Managers will inspect all residents to ensure equipment is present, in good condition, and in use as ordered. Root cause identified as supervisor rounding and follow-up as well as nursing staff training related to Kardex use. 4. The Director of nursing or administrative nurse will audit residents with pressure ulcers weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success with adherence to Kardex and Care Plan Compliance. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11.11.2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 37 2/10/24 - 2/15/24 - R129 was admitted to the hospital. 2/19/24 - 2/27/24 - R129 was admitted to the hospital. 2/27/24 5:56 PM - An admission/readmission assessment documented that R129 was readmitted from the hospital with the continued open area to the right ear and new open areas to the great and second toes on the left foot. 2/28/24 - A wound care assessment documented that R129's formerly documented right ear abrasion was a stage 3 pressure ulcer. The open areas's to R129's toes were documented as arterial at that time. 3/1/24 - 4/19/24 - R129 was admitted to the hospital. 4/19/24 10:57 AM - An admission/readmission assessment documented R129 was readmitted to the facility with pressure ulcers to the right ear and left toes. 4/20/24 - A physicians order was written for R129 to have a donut shaped pillow to right ear to relieve pressure. 4/29/24 - R129's open areas to left first and second toes that were formerly documented as arterial were assessed as unstageable pressure ulcers following diagnostic imaging results. 6/3/24 - R129's pressure ulcer to the second toe was resolved.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 38	F 686		

6/20/24 - R129's care plan for risk for additional pressure ulcers and skin breakdown was updated to include a foot cradle [metal bar that raises linen to prevent it from touching the patient] to the bed to prevent pressure from sheets. The care plan continued to have the intervention for the adaptive pillow.

7/22/24 7:20 AM - A wound care assessment documented that the stage three pressure ulcer to R129's right ear was resolved. R129's left great toe stage three pressure ulcer was improving without complications.

7/29/24 11:55 AM - R129 was observed in the bed and the adaptive neck pillow was absent. R129's feet were covered with blankets, no foot cradle was observed on the bed.

7/30/24 9:38 AM - R129 was observed in the bed and the adaptive neck pillow was absent. R129's feet were covered with blankets, no foot cradle was observed on the bed. A dry erase sign on the wall contained the following written message "Leave feet uncovered - Mom".

8/1/24 - The Kardex documented the resident was to receive an adaptive pillow to be positioned on right side of head at all times, make sure his ear in side the center cut. Task- foot cradle and pillow on.

8/1/24 11:03 AM 11:18 AM - During a dressing change observation with E51(LPN) R129 was observed in the bed there were bright red stains on the sheets and pillowcase near R129's head, R129 did not have the adaptive neck pillow in place. R129's feet were covered with blankets. E51 removed the blankets and stated, "They are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 39 supposed to keep them uncovered but therapy and the aides come in and they cover them up." When the surveyor inquired about the red liquid stains on R129's bedding, E51 stated, "His right ear must've reopened, I will get new orders." 8/1/24 11:50 AM - R129 was observed in the bed foot cradle bar on the floor, resident's feet were uncovered, and a dressing to the right ear was intact. There was no adaptive pillow present on the resident. 8/1/24 1:31 PM - R129 was observed in the bed, the adaptive neck pillow was absent. R129's feet were covered with a blanket and no foot cradle was on the bed. 8/1/24 2:09 PM - E50 (LPN) and E35 (CNA) accompanied the surveyor to R129's bedside and confirmed that the residents adaptive neck pillow was not in place and that the foot cradle to keep the resident's feet uncovered was not in place. E50 stated, "I need to check the orders first to see if they are supposed to be there, I don't know this patient." During an interview on 8/2/24 at 12:33 PM E18 (LPN/UM) confirmed that R129 was supposed to receive a neck pillow and have feet uncovered. E18 stated, "The neck pillow I know that we have been having some issues and I expect that to be reevaluated. I've gone in and not seen it but typically that was during care. I rely on the cart nurses to ensure that things are being completed throughout the day. Once the cradle came, we knew it didn't raise the blankets high enough. His Mom has a note not to cover his feet but as you see staff still does."	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 40 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that for one (R105) out of seven residents reviewed for activities of daily living (ADLs), the facility failed to ensure that R105 received the treatment/services to prevent further avoidable reduction of ROM and mobility. The facility lacked evidence that the palm device was applied to prevent further worsening of contractures to R105's left hand as recommended. Findings include: Review of R105's clinical record revealed:	F 688	F-688 1. Upon discovery R-109s palm guard was applied as ordered. 2. All residents requiring the use of adaptive equipment for range of motion have the potential to be affected. 3. An audit of all residents with orders for adaptive equipment will be conducted by the Director of Rehab. Audit will include listing of adaptive equipment on resident Kardex and ensuring adaptive equipment is in good working order and present in	11/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 41 10/26/23 - R105 was admitted to the facility with diagnoses including but not limited to multiple scelrosis (nervous system disease that affects the brain and spinal cord), chronic pain and muscle weakness. 10/26/23 - Review of R105's care plan for chronic pain to hands related to MS (Multiple Sclerosis) and neuropathic pain revised 2/19/24 interventions included...1. Left hand palm guard worn at all times remove for skin assessment at shift change and for hygiene." 2/7/24 2:44 PM - A order writen for R105 included left hand palm guard to be put on after AM care and removed after PM care with skin check at shift change every day and evening shift for wound care. 5/1/24 - A quarterly MDS (Minimum Data Assessment) documented R105 required substantial maximum assistance with upper body dressing and was dependent for lower body dressing. 7/31/24 10:32 AM - During an interview R105 stated, "I'm suppose to wear a splint on my left hand but they never put it on, you see where its at sitting up in that wire basket up there." 7/31/24 12:50 PM- R105 was dressed and not wearing the left hand palm guard. 7/31/24 1:29 PM- R105 stated, "nobody offered to put the splint on after I got was washed up, I'm not sure who is supposed to put it on, if it's the nurse or the aide, nobody ever told me who is suppose to put it on."	F 688	resident□s room, as well as ensure care plan is up to date. Nursing Staff will be educated on use of adaptive equipment and checking resident Kardex for adaptive equipment by SDC or designee. Unit Managers will be educated on purposeful rounding including but not limited to checking for adaptive equipment being used as ordered by the Director of Nursing. Use of adaptive equipment will be added to Unit Manager Daily rounds sheets. Unit Managers will complete rounds on 100% of residents M-F and Weekend Supervisors will complete rounds on 100% of residents Saturday and Sunday to ensure adaptive equipment is being used as ordered. Rounds sheets will be submitted to the DON daily for review. Root cause identified as supervisor rounding and follow-up as well as Kardex use. 4. The Director of nursing or administrative nurse will audit residents with orders for adaptive equipment weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success on adaptive equipment order compliance. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11.11.2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 42	F 688		

8/1/24 10:00 AM - Review of R105's kardex (references resident information for their care plan) special needs included...1. "Left hand palm guard worn at all times remove for skin assessment at shift change and for hygiene."

8/1/24 11:52 AM - R105 was observed in activities and not wearing the left hand palm guard.

8/1/24 1:47 PM - R105 was in bed and not wearing the left hand palm guard. R105's left hand palm guard was sitting in a wire basket on top of the dresser.

8/1/24 2:13 PM - During an interview and observation E9 (LPN-UM) entered R105's room and took the left hand palm guard out of the basket and asked [R105], "are you suppose to wear this at all times?" R105 stated, "yes" to E9. E9 then stated, "I will have to educate the staff about it."

8/1/24 2;22 PM - During an interview E13 (Rehab. Director) stated, "[R105's] left hand palm guard is to prevent any further contractures to the left hand." E13 stated, "it should be on after AM care and off in the PM."

8/12/24 1:34 PM - Findings were confirmed with E2 (DON) and E3 (ADON).

The facility lacked evidence that R105's palm device was applied to prevent further worsening of contractures to the resident's left hand as recommended.

8/12/24 2:15 PM - Findings were reviewed with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 43 E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for three (R324, R170 and R270) out of 14 residents reviewed for accidents, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents. For R324, the facility failed to transfer R324 with a hoyer lift per the plan of care. For R170, the facility failed to provide supervision while care was being provided by a staff member. For R270, the facility failed to put the wheelchair foot rests on prior to transportation. Findings include: 1. Cross refer to F580, example 1 R324's clinical record revealed: 6/12/24 - R324 was admitted to the facility for rehabilitation with diagnoses that included, but were not limited to, glioblastoma (brain tumor) status post craniotomy (brain surgery) in February 2024, seizure disorder, lack of coordination, and long term use of blood thinning medication.	F 689	F-689 1. Incident relating to R-324 was from a facility self-reported incident and prior to the time of survey. R-324 no longer resides at the facility and did not reside there at the time of survey. Incident relating to R-170 was from a facility self-reported incident and prior to the time of survey. Incident relating to R-270 was from a facility self-reported incident and prior to the time of survey. R-270 no longer resides at the facility. 2. All residents have the potential to be affected. 3. Relating to R-324, Nurses and CNAs were educated by Staff Development Coordinator/Designee on use of Hoyer Lift and Kardex. Root cause identified as employees needing to use the Kardex prior to providing care. New Hire Orientation was updated to include Hoyer Lift and Kardex. Relating to R-270, facility staff were educated by Staff Development	11/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ____ B. WING ____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 44 6/12/24 at 12:48 PM - R324's admission nursing collection tool documented that R324 was oriented at all times; had no history of falls; was bedbound; adequate vision; and was not able to perform walking assessment at this time. 6/12/24 at 1:33 PM - R324's weight was 210 lbs. 6/13/24 - A care plan documented that R324 required assistance with activities of daily living, including the use of a hoyer lift for all transfers with two (2) staff. 6/18/24 - The admission MDS assessment documented that R324 was dependent for transfers. 6/22/24 at 6:25 AM - A fall note by E52 (RN/House Supervisor) documented, "Pt (Patient) was being transferred by CNA when their leg (sic) began to feel weak and the patient felt as though they were going to fall. The CNA that was present lowered her to the ground slowly, preventing harm to Pt at approximately 06:00 AM. Pt stated 'I felt weak and couldn't stand anymore.' Pt was assessed by RN. Pt PERRLA is intact at this time. Pt shows no sign of injury. Pt is able to perform Active ROM with right sided extremities and passive ROM on the left sided extremities which is her baseline. Pt was then assisted in to bed via Hoyer lift...". 6/22/24 at 6:30 AM - A statement by E53 (CNA) documented that "A co-worker asked me to help him to place [R324] on her wheelchair. We got into the room, then we were trying to put her on her wheelchair. Her CNA [E54] put [R324] on her chair, but she felt uncomfortable so she asked	F 689	Coordinator/Designee on use of leg rests prior to ambulating a resident. Root cause identified as facility needing to implement this as a facility-wide policy with education and oversight. This was also added to new hire orientation. Relating to R-170, nursing staff will be educated by the Staff Development Coordinator on monitoring residents during care. Root cause identified as employees needing education. 5. Date of completion: 11.11.2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 45	F 689		

him if we are going to leave her on the chair like she was. I asked her if she wants to go back on (sic) bed and she said yes. [E54] was trying to put her on the bed, but he couldn't. He was holding her so I told him to lay her down on the floor so she won't fall and hit with something. [E54] told me to get the nurse so I went to get the nurse and he stayed on (sic) the room with her. She didn't fall because [E54] lay (sic) her down on the floor."

In response to R324's 6/22/24 incident, the facility implemented the following corrections:
- on 6/28/24, the facility's Education Attendance Sheet by E2 (DON) documented that E53 (CNA) and E54 (CNA) received one to one education regarding failure to check patient Kardex (care plan) for transfer status and return demonstration to pull up Kardex for transfer status. In addition, all staff were also in-serviced by 6/28/24 in response to this incident.
- from 7/1/24 through 8/8/24, the facility conducted audits of staff checking the Kardex and transferring residents using hoyer lift with two (2) staff.

8/6/24 at 12:25 PM - During an interview, E52 (RN) confirmed that the two CNAs did not use a hoyer lift when transferring R324.

2. Review of R170's clinical record revealed:

7/17/24 - R170 was admitted to the facility with multiple diagnoses including sleep apnea, left sided weakness, lack of coordination, and unspecified convulsions.

7/23/24 - An admission MDS assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 46	F 689		

documented R170 as cognitively intact. R170's functional ability was assessed as impaired on the one upper extremity, and partial moderate assistance needed for rolling in the bed. Partial moderate assistance is defined as the helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. R170 had a history of falling in the last 2-6 months prior to admission.

7/17/24 - A care plan created for R170 included a care plan for risk of falls. Interventions for that care plan included remind the resident to use their call light to ask for assistance with ADL's and place common items in reach.

7/18/24 - A PT evaluation and plan of treatment indicated that R170's bed mobility, roll left to right required partial/moderate assist, moderate assist with left side. The assessment summary indicated that R170 had body awareness deficits and decreased safety awareness.

7/25/24 - A fall risk assessment completed for R170 indicated the resident was at high risk to fall with a score of 12. High risk is a score greater than or equal to 12.

7/26/24 12:17 AM - A fall note in R170's clinical record documented, "This writer was called to resident room stating resident fell. Found resident on right side of the bed, resident was lying on his side on his left side. Resident ear and left eye was lying on the bed cord. Resident states he does not know what happened but fell. Resident was with staff in the room and resident rolled over from the bed, resident complained of mild pain on his left side where he was lying on. Skin tear measuring 1.5 cm to the side of his left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 47	F 689		

eye...Resident has left sided weakness as is baseline and is able perform passive range of motion to his right side. Resident [family member] made aware and NP made aware. Neuro checks initiated . Resident [family member] would like [R170] sent to the hospital to get CT scan of his head. What interventions were in place at the time of the fall?: Resident bed was in the lowest position and room well lit. What are the risk factors that could have contributed to the fall?: Unsteady gait, left sided weakness."

7/26/24 1:26 AM - Hospital records documented that R170 arrived to the hospital and received a CT of the head that did not show injury.

7/26/24 12:51 PM - A progress note in R170's clinical record documented, "Resident returned from ER Visit as per report, blood work and CT Scan was done and results were reassuring. No new orders at this time. Resident family and E6 (NP) made aware. Resident in his bed with all fall precautions in place."

7/26/24 - R170's risk to fall care plan was revised to include the following interventions, bilateral fall mats, CNA education, perimeter mattress and place bed in lowest position while resident is in bed.

7/29/24 - A progress note written by E6 (NP) documented that R170 was "Seen and examined laying in bed. Patient had a fall yesterday and was sent to ER. Imaging was unremarkable and patient returned. Patient denies any pain today."

8/2/24 - A follow up incident report was submitted to the State Agency that indicated, "Resident possibly falling asleep while care was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 48	F 689		

Combined with inability to stop self from falling related to left sided weakness were factors causing him to fall from his bed. While the CNA turned away after removing the draw sheet to drop it with the dirty brief, he heard the resident make a sound...and witnessed him rolling off the bed. System changes included education related to change draw sheet and repositioning patient on the draw sheet."

During an interview on 7/30/24 at 10:40 AM, R170 stated, "I fell because of them... I fell and then he went and got someone and they checked me out. Then they got me back up with a Hoyer lift. I called my sister and told her and she told them to send me to the hospital. I was there about a day but they didn't find anything wrong." When R170 was asked if he was able to roll in bed independently R170 stated, "Yes. But I was turning on my weak side and I kept going. I rolled and kept on going". R170 then confirmed that he was not provided assistance when turning in the bed.

During an interview on 8/6/24 at 8:59 AM, E47 (CNA) stated that R170 "Was laying on his back his left side was weak I rolled him wiped him then I rolled him on his right side removed the draw sheet and turned to drop it on the floor and when I turned around it was mid fall..I went to get the nurse on my hall." E47 then stated, that R170 was a "One person assist, limited he can help you turn with a small nudge and he usually stay's put. I assume he nodded off because he was sleep with the cpap on when I first came in to change him." E47 confirmed that when R170 rolled out of bed, E47 was not providing support or assistance, and the E47 had "turned around to drop soiled linen". E47 stated,"I am scheduled for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 49	F 689		

additional training. I guess the facility feels I improperly turned him and I should have had one hand on him."

3. Review of R270's clinical record revealed:

7/8/24 - R270 was admitted to the facility.

7/8/24 - The admission assessment documented R270 has at a risk to fall with a score of 16.

7/8/24 - A risk for falls care plan was created for R270. The interventions implemented included place common items within reach of the resident, and remind the resident to use their call light to ask for assistance with ADL's.

7/15/24 - A PT fall risk assessment documented that R270 had three falls in the past year. R270 was high risk to fall and had poor safety awareness.

7/16/24 -Review of the transportation form for R270's transportation to dialysis indicated, transfer status wheelchair.

7/23/24 9:04 - A fall note documented, "Description of the fall injuries if any: Small round laceration (.3 cm) to center of forehead. Scant bleeding. Band aid applied. Resident states an absence of pain. Resident is alert and oriented, answering questions appropriately. Resident states he desires to go to dialysis treatment...What are the risk factors that could have contributed to the fall?: Resident's footrests were not in place...What new interventions were implemented in response to the fall? Ensure footrests are in place at all times during assisted wheelchair mobility."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 50	F 689		

7/23/24 9:31 AM - A progress note in R270's clinical record documented, "Resident sustained a witnessed fall. This writer was called by a staff member who informed this writer that resident had fallen out his wheelchair in the hallway during transport out to dialysis. Resident stated that he still wishes to go out for his dialysis treatment. Vitals obtained, ADON aware, NP notified, and Daughter."

7/23/24 3:20 PM - A progress note in R270's clinical record documented, "Prior to and during the time of the fall, resident was being transported, via wheelchair, by ambulance service personnel."

7/23/24 - R270's care plan was updated to include ensuring foot rest are in place at all times during assisted wheelchair mobility.

7/27/24 - The post fall documentation assesment indicated, "[R270] fell on 7/23/24. Resident stated his foot got on the tile".

7/30/24 - A follow up incident report submitted to the State Agency documented, "Assisted propulsion in wheelchair without leg rest in place caused resident's foot to come in contact with the floor causing him to fall from the wheelchair."

During an interview on 7/29/24 at 3:49 PM, R270 stated, "I fell in the hall with no foot rest on, my foot got caught up about a week ago."

During an interview on 8/1/24 10:46 AM, CW1 (TA) was observed transporting R270 to dialysis who had foot rest on the wheelchair at that time. When asked if the residents foot rest were on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 51 prior to being transported CW1 stated, "If not we apply them because we are trained not to transport them without them." During an interview on 8/5/24 at 10:59 AM, E18 (LPN/UM) stated, "Ideally the CNA should've put them [foot rest] on and transport should wait at the desk for the resident but that did not happen." During an interview on 8/6/24 at 10:33 AM, E49 (COTA) confirmed that she assisted R270 the morning of his fall. E49 stated, "I went in he was anxious because he had dialysis and wanted to get ready, so we got up did ADL's. Then we were in morning meeting I remember them saying he fell." E49 confirmed she assisted R270 into the wheelchair without his leg rest and stated, "It's because if they get around it can be a hindrance. If they're going to be transported or I'm transporting them I know to apply them but that wasn't said before." 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 689		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's	F 690		11/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 52 comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, it was determined that for five (R90, R111, R118, R165 and R170) out of five residents reviewed for bowel and bladder assessments, the facility failed to conduct bowel and bladder assessments to develop an individualized care plan to restore and maintain their bladder and bladder continence to extent possible. Findings include: 11/1/19 - A facility document titled, "Assessment for Bowel and Urinary Toileting Program" documented, "Licensed nurse will perform a	F 690	F690 Bowel and Bladder Incontinence 1. For Residents R90, R111, R118, 170, a voiding diary was completed for each and is being reviewed to determine need for toileting plan for each. Resident R165 no longer resides at the facility. 2. All residents have the potential to be affected. The Director of Nursing/designee will audit residents POC of incontinent episodes and complete 3-day voiding diary and review for implementation of toileting plan as indicated. Results will be reviewed, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 53 bowel and/or urinary assessment on admission, readmission, annually, and PRN using the RAI process ...Bowel and urinary toileting approaches will be documented in the care plan ...evaluation of the toileting program will be documented in the Nurses Progress Notes." 1. Review of R90's clinical revealed: 6/15/24 - R90 was admitted to the facility with diagnoses including heart disease and high blood pressure. 6/15/24 - R90's admission nursing assessment documented, "Continent of bladder, continent of bowel." 6/15/24 - R90's toileting care plan documented, "The resident (R90) is incontinent of bladder and bowel. Provide toleting hygiene." The care plan lacked individualized approaches for toileting. 6/26/24 - R90's admission MDS assessment documented, "Occasionally incontinent of bladder, occasionally incontinent of bowel. Partial to moderate assist to get on and off the toilet." R90's MDS assessment documented a BIMS of 15, indicating a cognitively intact mental status. 8/2/24 9:00 AM - R90's Kardex (electronic information for the aides) documented, "One-person limited assist for transfers. Provide toileting hygiene." 8/2/24 12:30 PM - During an interview, R90 stated, "I used to use the bathroom when I was at home, but I use Depends here and I run out of them." The surveyor asked R90 if she was educated on or offered a toileting program to help	F 690	interventions implemented at that time based on results. 3. DON/designee will educate nurses and CNA□s on completing a 3-day bladder diary and review of completed documentation for implementation of a toileting plan as indicated. Root cause identified as lack of knowledge of the process of completing a 3-day voiding diary and the development of a toileting plan. Unit Managers will be educated by the Director of Nursing on reviewing 3-day bladder diary and implementing toileting plan as indicated. 4. The Director of nursing or administrative nurse will audit residents that are on a 3-day bladder diary daily until completion of the diary and audit the development of a toileting plan as indicated until 100% consecutively and then weekly for 4 consecutive weeks until facility reaches 100% success. Then monthly until the facility reaches 100% success for 2 consecutive months. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months 5. Date of completion: 11.11.2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 54	F 690		

remain continent. R90 stated, "No, no one talked to me about anything like that."

8/2/24 1:00 PM - During an interview, E12 (MDS Coordinator) stated, "Nursing does the assessments. I do the MDS based on what nursing documents." The surveyor asked E12 where the information for the care plan was obtained from, E12 repeated, "Nursing does the assessments. I do the MDS based on what nursing documents."

8/5/24 12:18 PM - A review of R90's clinical records lacked evidence of a bowel and bladder assessment to formulate a personalized plan of care for toileting. During an interview E7 (Unit Manager) stated, "I can't find a voiding diary for her (R90)."

8/5/24 12:26 PM - During an interview, E14 (CNA) stated, "I help her (R90) to wash up, she is often wet." The surveyor asked E14 about a toileting program for R90. E14 stated "No, it would be nice for her though."

8/6/24 10:00 AM - A review of R90"s clinical records from 7/8/24 to 8/6/24 revealed 64 episodes of urinary incontinence, and 2 episodes of bowel incontinence. R90's clinical records lacked evidence of a bowel and bladder assessment and a personalized plan of care to promote bladder and bowel continence.

2. Review of R111's clinical records revealed:

7/1/24 - R111 was admitted to the facility with diagnoses including urinary tract infection, acute pyelonephritis (kidney infection), and kidney stones.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 55	F 690		

Continued From page 55

7/1/24 - R111's toileting care plan documented, "Incontinent of bladder and/or bowels. Provide toileting hygiene." The care plan lacked individualized approaches for toileting.

7/11/24 - R111's admission MDS assessment documented a BIMS of 12, indicating a moderate cognitive impairment, and the urinary assessment documented, "Occasionally incontinent of urine..."

8/6/24 11:00 AM - During an interview, R111 stated, "I used to pee, and have a bowel movement on the toilet. Now I wear a diaper." R111 was observed to be wearing an incontinence brief.

8/6/24 1:04 PM - A review of R111's clinical records from 7/8/24 to 8/5/24 revealed 11 episodes of urinary incontinence.

8/6/24 1:30 PM - A review of R111's clinical records lacked evidence of a bladder and bowel assessment, and a personized toileting care plan.

3. Review of R118's clinical records revealed:

3/8/23 - R118 was admitted to the facility with diagnoses including high blood pressure and diabetes.

3/8/23 - R118's admission toileting care plan documented, "Frequently incontinent of bladder and bowels and is not a candidate for a toileting program due to inability to control bowel and bladder." The care plan lacked individualized approaches for toileting.

The facility failed to provide evidence of an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690		F 690		

Continued From page 56
assessment that was done at the time of admission that determined that R118 was unable to control her bladder and bowel.

6/18/24 - R118's quarterly MDS assessment documented a BIMS score of 15, indicating an intact cognitive status. R118's clinical records documented that supervision/touching from staff was required to get on or the toilet. The toileting assessment documented, "Always incontinent of bladder, frequently incontinent of bowel."

8/5/24 10:00 AM - During an interview, R118 stated, "I can stand to use the bathroom, but no one ever offers me to go to the toilet. I am embarrassed that I pee and poop on myself."

8/5/24 12:48 PM - During an interview E19 (CNA) stated, "I put her (R118) to bed and change her. I don't know about any toileting program."

8/5/24 2:00 PM - A review of R118's clinical records from 7/8/24 to 8/5/24 revealed that she was completely incontinent of bowel and bladder (78 episodes of urinary incontinence, and 51 episodes of bowel incontinence.)

8/5/24 2:30 PM - During interview with E7 (UM) the surveyor asked if R118 was assessed for a plan of care to promote bowel and bladder continency, E7 stated, "Not that I am aware of." A review of R118's clinical records lacked evidence of bowel and bladder assessments since her admission to the facility to formulate a personalized plan of care to promote bladder and bladder continency.

4. Review of R165's clinical records revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 57	F 690		

7/6/24 - R165 was admitted to the facility with diagnoses including a displaced fracture of her right knee and high blood pressure.

7/6/24 - R165's nursing admission assessment documented, "Incontinent of bladder, incontinent of bladder." R165's care plan documented, " ...incontinent of bladder and/or bowels." The care plan lacked individualized approaches for toileting.

7/17/24 - R165's admission MDS documented a BIMS score of 10, indicating moderative cognitive impairment. The MDS documentation included, "Frequently incontinent of bowel and bladder," and required substantial assistance to stand.

7/24/24 - R165's physical therapy records documented, "Cleared by orthopedic for weight bearing as tolerated."

8/5/24 1:34 PM - During an interview R165 stated, "I don't know what I am doing here, I put my call bell on and wait a long time for someone to come and take care of me. I have never been to the toilet since I got here. I must go on myself. It's not good, I am very angry about it."

8/5/24 11:30 AM - During an interview E29 (CNA) stated, "I change her (R165) in bed, and she is always incontinent."

8/5/24 1:46 PM - During an interview E30 (OT) stated, "She (R165) is weight bearing" A review of R165's physical records revealed that she is ambulate up to 10 feet with supervision.

8/5/24 2:PM - E7 provided the surveyor with a document titled, "3-day voiding diary." The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ________ B. WING ________	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 58	F 690		

document was incomplete and lacked evidence of an evaluation.

8/5/24 2:30 PM - During an interview, F2 (R165's daughter) stated, "I don't know how she (R165) is going to be able to come home like this. She does not even go to the bathroom. I don't know what this place is doing for her."

8/5/24 3:00 PM - A review of R165's clinical records from 7/8/24 to 8/5/24 revealed 118 episodes of bladder incontinence, and 60 episodes of bowel incontinence. R165's clinical records lacked evidence a toileting assessment to formulate a personalized plan of care to promote to promote bladder and bladder continence.

5. Review of R170's clinical records revealed:

7/17/24 - R170 was admitted to the facility with diagnoses including muscle weakness, urinary tract infection, and urinary retention.

7/17/24 - R170's nursing admission assessment documented, "Incontinent of urine and bowel."

7/17/24 - R170's toileting care plan documented, "The resident is incontinent of bladder and/or bowels. Provide toileting hygiene." The care plan lacked individualized approaches for toileting.

7/29/24 - R170's admission MDS assessment documented a BIMS of 14, indicating a cognitive intact status. The MDS also documented, "Frequently incontinent of urine, always incontinent of bowel." R170's clinical records documented, "1-person extensive assistance for transfers."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 59 8/5/24 1:10 PM - During an interview, R170 stated, "I try to use the urinal, but it does not always work, I used to sit on the toilet at home." 8/5/24 1:30 PM - During an interview, E35 (CNA) stated "I don't know if he (R170) can use the toilet. I change him when he is wet." 8/5/24 2:00 PM - A review of R170's clinical records from 7/18/24 to 8/4/24 revealed 29 episodes of urinary incontinence, and 19 episodes of bowel incontinence. 8/5/24 2:30 PM - During an interview E18 (UM) stated "We do a 3-day voiding diary on admission." The facility lacked evidence of a 3-day voiding diary or toileting plan. 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 690		
F 691 SS=D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for one (R111) out of two residents reviewed for nephrostomy	F 691	F691 1. Upon discovery, R111□s nephrostomy bag was moved the correct	11/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 691	Continued From page 60 catheter, the facility failed to provide safe and sanitary urinary catheter care to prevent urinary infections to the extent possible. Findings include: Review of R111's clinical records revealed: 7/1/24 - R111 was admitted to the facility with diagnoses including urinary tract infection, acute pyelonephritis (kidney infection), and right nephrostomy tube (a tube inserted into the kidney to drain urine because of kidney stones.) R111's hospital discharge records included, "Follow up in one week for urology consult for removal of kidney stones." 7/11/24 - R111's admission MDS assessment documented a BIMS of 12, indicating a moderate cognitive impairment. 7/3/24 - R111's MAR documented, "Empty nephrostomy drainage bag every shift." 7/30/24 8:30 AM - R111 was observed lying on the bed. An undated urinary collection bag with yellow urine was observed on the left-hand side of the bed. 7/30/24 9:30 AM - R111 was observed lying on the bed. An undated urinary collection bag with yellow urine was observed on the left-hand side of the bed. 7/30/24 10:30 AM - R111 was observed lying on the bed. The undated urinary collection bag with yellow urine was observed on the left-hand side of the bed. 7/30/24 2:00 PM - A review of R111's clinical records (physician's orders, MAR, TAR, Kardex,	F 691	level. 2. Residents with urinary catheters have the potential to be affected. 3. SDC will educate nursing staff on care and placement of urinary catheter. Root cause identified as nursing staff not being educated on care and placement of urinary catheters. Placement of urinary drainage bag added to Unit Manager Rounds sheets. 4. Unit Managers/designee will audit residents requiring use of urinary drainage bag weekly x 4 weeks until 100% consecutively and then monthly x 3 months consecutive months until facility reaches 100% success. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months 5. Date of completion: 11.11.2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 691	Continued From page 61 care plans) lacked evidence of a urology consult. 7/30/24 3:00 PM - Findings were confirmed with E41 (LPN). 7/31/24 - R111's urinary catheter collection container was observed on the floor of the room at 8:30 AM, 9:30 AM and 10:00 AM. 7/31/24 10:30 AM - Findings were confirmed with E2 (DON). 8/3/24 10:35 AM - R111's clinical records documented, "Urine sample obtained." 8/5/25 7:00 PM - R111's physician orders documented, "Macrobid Oral Capsule 100 milligrams [antibiotics], give 1 capsule by mouth two times a day for UTI {urinary tract infection} for 7 days." The facility failed to provide safe and sanitary nephrostomy catheter care to prevent urinary tract infections. 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 691		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		11/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 62 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for one (R90) out of one resident reviewed for respiratory care, the facility failed to ensure that R90 received oxygen per physician's order. Findings include: Review of R90's clinical record revealed: 6/15/24 - R90 was admitted to the facility with diagnoses including heart disease and high blood pressure. 6/15/24 - R90's respiratory care plans documented, "At risk for respiratory complications due to asthma and hypoxemia (not enough oxygen reaching body tissues), administer oxygen as ordered." 6/17/24 - R90's clinical records included oxygen at 2 liters per minute via nasal cannula (a medical device used to provide supplemental oxygen therapy to people who have lower oxygen levels). 6/26/24 - R90's MDS documented, "Continuous oxygen therapy." 7/29/24 9:30 AM - R90 was observed lying on the bed. The oxygen tubing was observed on the floor on the left-hand side of the bed. 7/29/24 10:30 AM - R90 was observed lying on the bed. The oxygen tubing was observed on the floor on the left-hand side of the bed. 7/29/24 11:30 AM - R90 was observed lying on	F 695	F695 1. Upon discovery, R90□s oxygen was applied to the resident. 2. Residents with orders for oxygen have the potential to be affected. The Director of Nursing/designee will audit all residents with orders for oxygen and ensure residents receive oxygen per the physician□s order and all orders are up to date for resident□s current status. 3. SDC will educate licensed nurses to ensure the physician orders are followed for residents with oxygen. Unit Managers will be educated by DON on checking for oxygen use as ordered while completing rounds. Rounds sheet will be updated to include checking for appropriate oxygen use. Round sheets will be submitted to DON daily M-F. Root cause identified as purposeful supervisor rounds to identify oxygen tubing in place per order. 4. The Director of nursing or administrative nurse will audit UM Rounds Sheets to weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success to ensure oxygen tubing is in place. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11.11.2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 63 the bed. The oxygen tubing was observed on the floor on the left-hand side of the bed. 7/29/24 12:00 PM - Findings were confirmed with E41 (LPN). The facility failed to ensure that R90 received oxygen therapy per physician's orders. 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R173) out of one resident reviewed for pain management, the facility failed to provide pain management according to professional standards of practice. R173 was not provided pain medication since before admission to the facility at 11:00 AM until pain medication administration at 7:08 PM, an estimated eight hours. The facility's failure to administer pain medication caused R173 to experience unnecessary pain related to a recent amputation. Findings include: The facility policy on pain management last updated 1/29/24 indicated, "If pain is not relieved,	F 697	F-697 1. Upon discovery, F-697 was provided pain medication per orders. 2. All new residents admitting to the facility with orders for narcotic pain medications have the potential to be affected. A two-week lookback of newly residents will be conducted to ensure all admission orders are followed. 3. Root cause identified as lack of nursing familiarity with ordering narcotic pain medications from the pharmacy and following professional standards of practice including conducting an immediate pain assessment of a newly	11/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 64 notify the provider." The facility policy on admitting a new patient, last updated 1/29/24 indicated, "Obtain provider's orders or verify transfer orders with attending physician for the patient's immediate care." Review of R173's clinical record revealed: 7/27/24 - Hospital interagency discharge orders documented R173 was "admitted to the hospital with a foot infection and underwent an above the knee amputation of the right leg, and amputation of the left fifth toe". Discharge diagnoses included the amputation, and cellulitis of the left foot. Medication orders upon discharge included oxycodone 5 mg two tablets by mouth every four hours as needed for severe pain 7/10. 7/27/24 - R173 was admitted to the facility with multiple diagnoses including surgical amputation. 7/27/24 untimed - A careplan was created for risk of pain related to recent surgery with a goal the resident pain will be resolved. Interventions included administer medications, as ordered. Notify physician as ordered. Observe for physical indicators of pain. 7/27/24 untimed - A physician order was created for R173 to receive oxycodone 5 mg two tablets by mouth for every four hours as needed for severe pain 7/10. Pain assessments every shift. Administration of non-pharmalogical pain interventions as needed for pain management. 7/27/24 11:40 AM - E16 (LPN) documented in an admission note in R173's clinical record, "Patient arrived at 11:00 [AM]".	F 697	admitted resident and reviewing admission orders for narcotic pain medications. SDC will educate licensed nurses on conducting a pain assessment for newly admitted residents upon admission. SDC will educate licensed nurses on process for ordering narcotic medications from Pharmacy. 4. The Director of nursing or administrative nurse will audit newly admitted residents weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success with new admission orders for narcotic pain medication. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11.11.2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 65	F 697		

7/27/24 12:42 PM - An admission assessment in R173's clinical record documented, "Cognitively intact, oriented to person, oriented to place, oriented to time, oriented to situation. Pain presence frequently that makes it hard to sleep at night and limits day to day activity. Facial expression of pain such as grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw. Received scheduled pain medication regimen 'no'. Received PRN pain medications or was offered and declined 'no'." The attached admission narrative note documented, "Complain of pain 6/10 and was medicated prior to leaving the hospital." R173's clinical record lacked evidence that a physician was contacted regarding the need for additional pain management interventions.

7/27/24 7:08 PM - The facility pharmacy report revealed that two 5 mg oxycodone tablets were retrieved from the facility back up medication machine by E18 (LPN) (UM) and E16 (LPN) as witness for administration to R173.

7/27/24 7:57 PM - E16 (LPN) documented, R173 was cognitively intact, having right knee pain and that a PRN medication was administered. Review of R173's MAR lacked evidence that any pain medication was administered to the resident.

7/27/24 - R173's MAR did not have any administrations of oxycodone or any other pain medication documented additionally there was no preadministration pain scale or post administration pain scale for the above mentioned medication retrieved at 7:08 PM.

7/27/24 - R173's MAR pain assessments to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 66	F 697		

completed each shift were absent of an assesment for the day shift, the evening shift assesment was 0/10, and the night shift assessment was 0/10. The admission assessment, and interviews with R173, E16 (LPN), E17 (LPN), and E18 (LPN) were inconsistent with a 0/10 pain assessment.

7/28/24 - R173's MAR documented that oxycodone was first administered at 6:03 AM for pain of 9/10, at 6:52 AM the follow-up pain scale was 1.

During an interview on 7/29/24 at 12:39 PM, R173 stated, "I didn't get pain medicine all day Saturday ([7/27/24), and into the Sunday (7/28/24) I just had an amputation!" When asked if she recalled her pain level at that time and whether she reported it R173 stated, "Yes, it got to 10/10. I started ringing again at 9:00 PM and they didn't tell me they didn't have my medication filled until 3:00 AM. I got something for pain at 6:00 AM." R173 stated that her pain during the interview was "fine."

During an interview on 8/5/24 at 10:51 AM, E18 (LPN) and (UM) stated, "The hospital was supposed to send prescriptions, but they did not. I got a hold of medication from the emergency stock." E18 was unable to provide evidence that a physician was contacted regarding R173's need of prescriptions for pain medication and that unmanaged pain was reported.

During an interview on 8/5/24 at 11:54 AM, E16 (LPN) stated, "The Saturday [R173] came in and we had to wait for her prescriptions. There is oxycodone in the (back up medication storage) but the physician's order for her wasn't available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 67 I could have pulled two. I remember she was in so much pain. I called her daughter to see if I could give her Tylenol." During an interview on 8/6/24 at 12:05 PM, E2 (DON) stated,"Sometimes they (patients) come in without prescriptions for the narcotics. If we get the patient early enough then the NP onsite will write the prescription. If not, then the on-call would be called and they would call into the pharmacy. If there was not an order, to make a call to the NP." E2 was unable to provide the surveyor with evidence that a physician or designee was contacted regarding the need for narcotic prescriptions for R173. During an interview on 8/6/24 at 12:21 PM, R173 denied receiving Tylenol on 7/27/24. R173 stated, "No, I don't take Tylenol it upsets my stomach. And are you kidding me! That would be like eating candy. That won't do anything for my pain." 8/8/24 9:00 AM - E2 (ADON) provided the surveyor with a transaction log from the facility's back up medication machine that documented, two tablets of 5 mg oxycodone were retrieved for administration to R173 on 7/27/24 at 7:08 PM. It is unclear why this administration was not documented on R173's 7/27/24 MAR. During an interview on 8/12/24 at 9:17 AM E17 (LPN) stated that R173 "Asked about her pain medicine but I don't remember exactly why because she did get some. When I talked to her, we told her we had to get a code from the pharmacy and we did get it out for her and she got it that evening." When asked if R173 complained of pain E17 stated, "I don't exactly remember, but she asked about pain medicine	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 68 but she didn't request pain medicine, but I suspected she might have been in pain because I knew she had surgery and I told her it [pain medication prescriptions] wasn't in yet but that we could get it for her once it came in. " During an interview on 8/12/24 at 1:45 PM E2, (DON) confirmed that the facility only administered pain medication to R173 on 7/27/24 at 7:08 PM. E2 stated, "With receiving it in the hospital it may not have been due. I"m going to see what time it had been given there". 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 697		
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 726		11/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 69 §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, review of clinical records including two incidents involving significant medication errors and other documentation as indicated, it was determined that for 29 out of 29 licensed nurses reviewed, the facility failed to have a system/process in place to ensure each licensed nurse had competencies and skills sets necessary to care for current residents' needs. - On 7/6/24, E43 (RN) administered another resident's medications to R322, which resulted in a serious adverse outcome. R322 required emergent admission to the ICU for treatment and monitoring. The facility failed to ensure E43 had a medication administration competency and skill set validated during his orientation. In addition, the facility allowed R322 to continue to administer medications for 14.5 days after the 7/6/24 incident without evidence of a competency and skill set validation for medication administration. An Immediate Jeopardy (IJ) was called on 8/26/24 at 7:07 PM. The IJ was abated on 8/30/24 at 5:00 PM. - On 8/18/24, E55 (LPN) administered another resident's medications to R95. The facility lacked evidence of E55's competency and skill set validation for medication administration during her	F 726	F-726 1. Upon discovery, R-95 was assessed and monitored for any adverse affects with none noted. 2. All residents have the potential to be affected. 3. Root cause identified as new-hire orientation (for in-house and agency staff) lacked required cross-reference with facility population and assessment to ensure licensed nurses are educated on care needs of facility patients. Licensed Nurses were educated by SDC and designee on policies, procedures and competencies for Enteral Feeding Tubes, Respiratory Care and oxygen equipment (including CPAP and BiPAP), wounds/skin-impairments, bladder scans, hemodialysis, urinary catheters, ostomy care, and blood glucose monitoring. Education was conducted for all scheduled nurses and facility maintains policy that no new nurses, agency nurses or nurses who have been away on leave may be scheduled for shifts until they have completed this full education with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ___ B. WING ___	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 70 orientation. - For 24 out of 24 nurses scheduled to work from 3 PM on 8/26/24 through 3 PM on 8/27/24 plus three additional nurses (E56, E57 and E58), the facility lacked evidence of each nurses' competency and skill set validations necessary to care for current residents' needs. Findings include: The facility assessment, dated 7/2024, documented, "... 1.1 The facility is licensed to care for 177 residents... 3.5 Staff training/ education and competencies. All staff members have a competency checklist upon hire that is completed during orientation to provide adequate care for our residents... Topics... Date Presented: Orientation & Annually, and as needed...". The facility's form entitled "Skills Validation Record for a Charge Nurse", last revised 5/2024, included the following sections: -General: job description, employee guide, required education, customer service, survey process, policies & procedures, QAPI, Residents' Rights, Safe smoking practices, Abuse; -Environment: facility tour, emergency eye wash stations, security practices, water shut off process, oxygen storage, call light system, phone/paging system, work orders, missing person process, emergency preparedness/red book review; -Infection Control: hand hygiene/glove usage; cleaning and disinfecting equipment; linen handling/appropriate bagging; transmission based precautions; PPE (donning/doffing); Vaccines; PPD/Screening; -OSHA: Bloodborne standard; Hepatitis B vaccine protocol; Regulated Medical Waste; Respiratory Protection Program (N95 fit test); Exposure	F 726	return demonstration. Medical needs of potentially admitted residents will be reviewed by Nurse Administration prior to admission to ensure nurse education aligns with resident needs and new education is provided as needed. 4. An audit of the schedule for each day, each following day and following weekend days is conducted daily by Staff Scheduler and Administrator to ensure all nurses working have received the educations. Unit Managers conduct daily skills competency audits with random nurses on assigned topics. Audits will continue for 90 days and will be brought to the QAPI Committee monthly for further review and recommendations. 5. Date of completion: 11.11.2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 71 Control (post exposure process); -Equipment: Glucometer; Coagucheck; Vital sign machine; CPAP/Bipap; Trach oxygen compressor; Oxygen concentrator/tanks; Nebulizer machine; Device(s) filter care; Suction machine; Mechanical lifts/scales; IV pump; Tube feeding pump; Wound vac; Air mattresses; Fall prevention devices; -Supervising CNAs: Observe hygiene; Shower schedule; Turning/repositioning; Documentation verification; Hydration; Snacks; Feeding assistance; Rounds; -Clinical Processes: Nursing chain of command; Central Supply; Medication room; Medication Pass Observation; Treatment Pass Observation; Refusal process; Behavior management; Restorative nursing; Restraints; Code status (DNR validation, advanced directives, etc.); Code blue; Dietary Processes and communications; Dialysis protocols (communication form, medication scheduled, documentation, etc.); Scheduling (appointments, procedures, transportation, etc.); Nursing documentation best practices (dos & donts sic); ADL documentation review; -Pharmacy Services: Admission orders (cut off times, admission alert); Back up pharmacy; Omnicell review (narcotic code, adding new user); Narcotic processes (shift count, discontinued, ordering); OTC medication procedure (Medline); -PCC (PointClickCare) Clinical Documentation: Admissions/Readmissions; Risk Management; Allergies; Batch Orders; Dashboards; Discharges; Elopement; Emergency EMAR backup; Falls; Immunizations; Infection Control Dashboard; Labs and Radiology; Entering IV solution orders; Entering SSI orders; Order entry; Overview Clinical; POC documentation; Progress	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 72 Notes; Receiving meds from Pharmacy and refills; Reports; Skin Assessments; Tasks; Weights and Vitals; -Clinical Skills Competencies: Intravenous catheters; Venipuncture; Enteral Feeding Tubes; Urinary Catheters (foley/suprapubic/straight/external); Ostomy; Respiratory Care; Tracheostomy; Wound Vac; JP Drain; and Center Specific Skills. 1. Cross refer F760, example 1 6/4/24 - E43 (RN) was hired by the facility. 7/6/24 at 3:40 PM - A nurse's note documented, "Patient was given medications that were prescribed for another resident...". 7/6/24 at 4:21 PM - The hospital record documented, "... presents to the ED (emergency department) with hypoglycemia (low blood sugar) and hypotension (low blood pressure) after receiving the wrong medications at his rehab facility... will need an ICU admission for management...". 7/11/24 - The facility submitted to the State Agency a five day follow up investigation and response to the 7/6/24 incident involving R322. In the follow up it stated that "All licensed nurses were re-educated on the rights of medication administration and medication competencies were performed." Review of the facility's follow-up documentation provided to the Surveyor for the 7/6/24 incident revealed that re-education/competencies of all licensed facility nurses were incomplete. In addition, the facility lacked evidence that E43's	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 73	F 726		

skills/competency was validated after this incident. E43 continued to work in the facility for 14.5 days after the 7/6/24 medication error incident.

8/26/24 at 12:50 PM - During an interview, E48 reviewed the facility's form entitled "Skills Validation Record for a Charge Nurse" that was being used to validate each nurse's competency and skills set. E48 (Staff Educator) confirmed that she had no evidence of E43's competency and skill set.

8/26/24 at 7:07 PM (revised 9/5/24) - During a meeting with facility management, the Survey Team notified E1 (NHA), E2 (DON 1) and E59 (DON 2) of an Immediate Jeopardy for the failure to have evidence of E43's competency and skill set validation during his new hire orientation, as outlined in the facility assessment.

8/26/24 at 9:07 PM - E1 (NHA) submitted a signed, dated and timed written abatement plan to the State Agency.

The facility's abatement included:
- "Licensed Nurses will be trained on the following competencies: enteral feeding tubes; respiratory care and oxygen equipment (to include CPAP and BiPAP); wounds/skin impairments; bladder scans; hemodialysis; urinary catheters; ostomy care; blood glucose monitoring.
- The first staff members to be trained will be the Unit Managers, Shift Supervisors, and Staff Development Coordinator. Training will then be completed by Licensed Nurse Managers (DON, ADON, Unit Managers, Staff Development Coordinator) as well as Licensed Nurse Corporate Level Clinical Directors and will include

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 74	F 726		

return demonstration. Training will (sic) conducted on a daily basis until staff threshold met.
- Licensed Nurses and Facility Manager will be educated on circumstances relating to Immediate Jeopardy tag.
- Pending admissions will be evaluated based on needs to ensure staff working have required competencies completed to provide care.
- Because the Center employs a high number of nurses and utilizes agency nurses when needed, education will be ongoing to ensure nurses are educated on the above competencies and the circumstances leading to this education.
- 100% of Licensed Nurses will receive education with return demonstration by date of abatement...".

8/30/24 at 5:00 PM - The IJ was abated based on interviews with licensed nursing staff and review of facility documentation of individual licensed nurses' competency and skill set education/validations of current residents' needs.

2. Cross refer F760, example 2

6/24/24 - E55 (LPN) was hired by the facility.

The facility provided the Surveyor the following information on E55's schedule upon hire:
-6/24/24 through 6/28/24, E55 was in classroom training;
-7/3/24 through 7/15/24, E55 was trained on the floor; and
-Starting 7/16/24, E55 was working on the floor by herself.

8/18/24 at 8:00 PM - The facility's incident report documented that R95 was administered R48's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 75	F 726		

prescribed medications by E55 (LPN).

8/26/24 at 12:50 PM - During an interview, E48 (Staff Educator) stated that she took over the position of Staff Educator at the end of April 2024. E48 stated that nursing orientation includes the first week with classroom review/training, then orientation with another nurse on the floor for 5 to 8 days, based on the nurse's experience. When discussing the facility's Skills Validation Records for nursing staff, E48 stated that the forms were not being returned to her timely. In fact, E48 stated that E55's Skills Validation Record appeared on her desk recently. While reviewing E55's Skills Validation Record with the Surveyor, E48 confirmed that it was not completed correctly. E55's Skills Validation Record was signed off by E52, an agency RN, but never signed by E55 herself. E52 printed and signed her name, and utilized a down arrow for each section, but did not record the date that each skill was reviewed and validated. E52 signed and dated page 6 in the Supervisor's Signature section and dated 7/14/24. In response, the Surveyor requested to see E52's Skills Validation Record since she signed attesting that she validated E55's skills. E48 confirmed that the facility lacked evidence of E52's Skills Validation Record.

Review of the facility's Employee Report revealed that E52's hire date was 10/31/23.

The facility lacked evidence of E48 and E52's competency and skill set validation.

3. Review of 100 out of 165 current residents in the facility revealed the following nursing care needs, but were not limited to:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 76	F 726		

-accucheck using a glucometer;
-dialysis access sites: chest wall or AV fistula, care and assessment of bruit/thrill;
-respiratory care (oxygen, nebulizer, CPAP, BiPAP, Aerobika, incentive spirometer, Acapella valve);
-bladder scan;
-urinary catheters: foley, straight catheter;
-wound care;
-enteral feeding: pH testing, checking placement, administering meds - G tube;
-colostomy;
-pacemaker;
-urostomy, nephrostomy; and
-Life Vest heart monitor.

8/26/24 at 3:50 PM - The Surveyor provided a list of the following scheduled nurses to facility management and requested each nurses' Skills Validation Record (Checklist):
E9 (LPN), E16 (LPN), E18 (LPN), E36 (LPN), E38 (RN), E42 (LPN), E50 (LPN), E60 (RN), E61 (LPN), E62 (LPN), E63 (LPN), E64 (LPN), E65 (LPN), E66 (RN), E67 (RN), E68 (LPN), E69 (LPN), E70 (RN), E71 (LPN), E72 (LPN), E73 (LPN), E74 (LPN), E75 (LPN) and E76 (LPN).

In response to the request, the facility was not able to provide the Surveyor with each nurse's most recent Skills Validation Record. The facility did provide some documentation on Relias web training completed by some nurses.

4. Review of E56's (LPN) training and competencies records indicated that the employee was hired 7/8/24. No completed nursing skills validation checklist could be located for E56.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 77 Review of E57's (Agency RN) training and competencies records indicated that the agency staff's first day in the facility 3/25/24. No completed nursing skills validation checklist could be located for E57. Review of E58's (Agency LPN) training and competencies records indicated that the agency staffs first day in the facility 6/24/24. No completed nursing skills validation checklist could be located for E58. 8/26/24 1:25 PM - During an interview, E48 (Staff Educator) stated that the staff were not retuning the skills checklist after their orientation period on the floor with their preceptors. E48 further confirmed that E56, E57 and E58 did not have the nursing skills validation checklist on their training files. The facility failed to ensure that the required nursing skills validation checklist was completed for 29 out of 29 nursing staff reviewed 8/26/24 2:33 PM - Findings were discussed with E1 (NHA). 8/27/24 2:52 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E10 (VPO).	F 726		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the	F 730		11/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 730	Continued From page 78 requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that a performance review was completed at least every twelve months for two out of five (E25 and E26) sampled employees. Findings include: 8/7/24 11:00 AM - Review of the staff performance evaluations revealed the following: 1. E25 (CNA) had a hire date of 3/20/07. A record review revealed lack of evidence of a performance evaluation for the past year and was confirmed by E34 (HR). 2. E26 (CNA) had a hire date of 3/4/08. A record review lacked evidence of a performance evaluation for the past year and was confirmed by E34. 8/12/24 1:34 PM - Findings were confirmed with E2 (DON). and E3 (ADON). 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 730	F730- Nuse Aide Perform Review 1. No residents were affected by the deficient practice. E25 and E26 will receive their annual performance evaluation by 10/4. 2. All residents have the potential to be affected by the deficient practice. A 100% audit of employee files for Nurse Aide Performance Review will be completed by the Human Resources Director/Designee. For those that are identified to have not been completed they will be completed by 10/4 with NHA being responsible to ensure completion. A Nurse aide performance review tracker will be developed to provide accurate tracking of dates of hire and dates of evaluation completions. 3. A root cause analysis identified the facility did not complete Nurse aide performance reviews every 12 months due to not having a tracking in place for evaluations when new HRD was hired. The Administrator will provide education to the HR director and staff developer that the facility must complete a performance review of every nurse aide at least once every 12 months and must provide regular in-service education based on the outcome of the reviews. In addition, the HRD maintains a tracker listing nursing aid, hire date and due date for review. The tracker will be kept on the facility electronic file system so when changes in personnel occur, the management team can still see who needs a performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 730	Continued From page 79	F 730	evaluation completed. 4. The Human Resources Director/Administrator will audit 5 current staff weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. 5. Date of completion: 11.11.2024	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.	F 756		11/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 80 (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R107) out of five residents reviewed for unnecessary medications, the facility failed to act on a pharmacy medication review recommendation for R107. Findings include: The facility Medication Regimen Review (MRR) policy number 1303, effective 1/29/24 documents the following: "Policy - The drug regimen of each patient will be reviewed at least once per month by a licensed pharmacist. Procedure ... 2. The physician is to review and sign the patient's individual MRR and document that he/she has reviewed the pharmacist's identified irregularities within 30 days of receipt ... A review of R107's chart revealed:	F 756	F-756 1. Upon discovery, the pharmacy recommendations for Resident R107 were reviewed with the physician and completed per policy. 2. All residents have the potential to be affected. A 30-day lookback audit was completed by the DON of monthly pharmacy recommendations and any missing documentation was corrected. Root cause determined to be physician lack of understanding of completion of monthly pharmacy recommendation reviews. 3. RDCS will educate facility physicians and NPs on Monthly Pharmacy Review policy. 4. The Director of nursing or administrative nurse will audit monthly pharmacy recommendations weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 81 7/21/23 - R107 was admitted to the facility. 3/19/24 - R 107 was assessed as being a high fall risk. 3/25/24 - A pharmacy medication review was done that documented that attention was needed by the provider to address a fall assessment review related to the side effects of medications that R107 was taking. The pharmacy review further documented that the medications could cause dizziness, and drowsiness. The medication review was signed and dated (unable to read the date) by E15 (MD) but there was no documentation by E15 that the pharmacist medication recommendation was acknowledged or reviewed. 8/01/24 10:02 AM - During an interview, E2 (DON) confirmed that R107's 3/25/24 medication regimen report did not have a documented review by E15 to acknowledge the pharmacist recommendation. 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 756	100% success. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11.11.2024	
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of clinical records and other documentation as indicated, it was determined that for one (R322)	F 760	F-760 1. Upon discovery of Medication Error, R322 was assessed and sent to hospital.	11/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 82 out of three residents reviewed for hospitalizations and three (R22, R33 and R95) out of nine residents reviewed for medication administration, the facility failed to ensure that residents were free of significant medication errors. On 7/6/24, R322 was administered R144's prescribed medications. As a result, R322 was emergently sent to the hospital requiring treatment and monitoring in the Intensive Care Unit (ICU). The facility's multiple failures involved in this incident had the potential to cause a serious adverse outcome or death to R322 with respect to receiving another resident's multiple blood pressure medications and diabetic medications. Due to the failures, an Immediate Jeopardy (IJ) was called on 8/23/24 at 2:08 PM. The IJ was abated on 8/26/24 at 11:59 PM. On 8/18/24, R95 was administered R48's prescribed medications. R95 remained in the facility and was monitored for adverse effects. For R22 and R33, the facility failed to ensure that each resident received their meals within 15 minutes of the administration of short acting insulin. Findings include: The facility's pharmacy policy and procedure entitled, "#8.2 General Guidelines for Medication Administration", last revised 08-2020, stated the following: "... Medications are administered as prescribed in accordance with good nursing principles and practices... Procedures:... I. Preparation... 4. At a minimum, the 5 Rights - right resident, right drug, right dose, right route, and right time - should be applied to all medication administration and reviewed at three steps in the process of preparation: (1) when medication is selected, (2) when the dose is removed from the container,	F 760	R322 did not reside in facility at the time of survey. Upon discovery of medication error, R95 was assessed and monitored for adverse effects with none noted. Physician/NP and Responsible party notified. Physician/NP□s instructions were followed. R33 and R22□s blood sugars were taken and found to be within baseline for the resident. 2. All residents have the potential to be affected. Immediate education provided for E-42 on insulin administration. E-55 was provided education on medication administration. E-43 no longer works at the facility and did not work at the facility at the time of survey. Root cause determined to be failure of nursing staff to adhere to Five-Rights of Medication Administration and other safety protocols. 3. Licensed Nurses were educated by Director of Nursing, SDC and DON on policy and procedure for medication administration. A medication administration observation was conducted for each nurse before each nurse could pass medications. Nurse Managers were educated by Director of Nursing on process for managing Medication Errors to mitigate adverse effects for residents involved and determine if any other residents were involved. Nurse Managers were educated by Administrator on requirements for reporting Medication Errors to the State. Unit Managers or designee will complete one medication pass observation per shift each week and provide immediate education as needed. Audits will be reported to the DON. 4. The Director of nursing or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ____ B. WING ____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 83 and (3) after the dose is prepared and the medication is put away... II. Administration... 4. When medications are administered by mobile cart taken to the resident's location..., medications are administered at the time they are prepared... 6. Medications are administered without unnecessary interruptions... 8. Residents are identified before medication is administered using one method of identification. Methods of identification may include but not limited to: a. Checking the photograph attached to the medical record. b. Calling the resident by name (except in residents with cognitive impairment). c. Having the resident verify his/her last name. d. If necessary, verifying resident identification with other facility personnel... 12. Medications are administered within 60 minutes of the scheduled administration time, except before, with, or after meal orders, which are administered based on mealtimes. Unless otherwise specified by a prescriber, routine medications are administered according to the established medication administration schedule for the facility... IV. Documentation (including electronic) 1. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given...". 1. Cross refer F726, example 2 Review of R144 and R322's clinical records revealed: For R144: 7/1/24 - R144 was admitted to the facility in room XXXX. 7/2/24, 7/3/24 and 7/5/24 - Review of the July 2024 eMAR, E43 (RN) administered R144's	F 760	administrative nurse will audit medication errors and medication pass observations weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success in management of medication errors. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11.11.2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ____ B. WING ____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 84 medications scheduled at 8:00 AM. R144 was scheduled to receive the following 13 medications on 7/6/24 at 8:00 AM: - Losartan Potassium 100 mg, 1 tablet, for hypertension (high blood pressure); - Coreg 12.5 mg, 1 tablet, for hypertension; - Hydralazine 50 mg, 1 tablet, for hypertension; - Spironolactone 25 mg, 1 tablet, for hypertension; - Metformin 1000 mg, 1 tablet, for diabetes mellitis (high blood sugar); - Glipizide 5 mg, 1 tablet, for diabetes mellitis; - Aspirin 81 mg, 1 tablet, for CVA (stroke) and heart health; - Sucralfate 1 gm, 1 tablet before meals scheduled at 7:30 AM, for stomach ulcer; - Omeprazole 40 mg, 1 capsule, for gerd (stomach acid flows back into the esophagus); - Tylenol 325 mg, 3 tablets, for pain; - Miralax powder, 1 scoop mix in water or juice, for constipation; - Senna 8.6 mg, 2 tablets, for constipation; - Symproic 0.2 mg, 1 tablet, for constipation; - FiberCon 625 mg, 2 tablets, for constipation. For R322: 7/3/24 - R322 was admitted to the facility for short-term rehabilitation with diagnoses, including but not limited to, pneumonia, chronic respiratory failure, pulmonary fibrosis (lung disease when lung tissue becomes damaged and scarred), chronic obstructive pulmonary disease (chronic inflammatory lung disease) and dependent on supplemental oxygen. R322's room was YYYY, which was located on a different hallway from R144. 7/5/24 - Review of the July 2024 eMAR, E43 (RN)	F 760		