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

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

STATE SURVEY REPORT

NAME OF FACILITY: Pinnacle Rehabilitation & Health Center **DATE SURVEY COMPLETED:** January 14, 2025

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 complaint survey was conducted at this facility from January 10, 2025, through January 14, 2025. 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 144. The sample totaled eight (8) residents.		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed January 14, 2025: F609 and F610.	Cross reference EPOC.	

Provider's Signature A Rodda, NHA Title Administrator Date 1-20-25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT BLVD SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from January 10, 2025 through January 14, 2025. 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 144. The sample totaled eight residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nursing Assistant; DON - Director of Nursing; FM - Family Member; LPN - Licensed Practice Nurse; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RN - Registered Nurse; SW - Social Worker; UM - Unit Manager. Alzheimer's disease - is a brain disorder that gradually destroys memory and thinking skills. It's the most common cause of dementia in older adults; 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; EMR - Electronic Medical Record; Medication Administration Record (MAR) - list of daily medications to be administered;	F 000		

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

Electronically Signed | 01/21/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Minimum Data Set (MDS) - standardized assessment forms used in nursing homes.	F 000		
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 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, record review and a review of other facility documentation, it was determined that for one (R1) out of three sampled residents	F 609	a. R1 has no adverse effect related to the deficiency.	3/3/25

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F 609	Continued From page 2 reviewed abuse, the facility failed to report an allegation of abuse. Findings include: Cross refer to F610 The facility policy titled "Abuse, Neglect, Exploitation" last updated, May 2024 indicated, " ...Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse ...". Review of R1's clinical record revealed: 1/2/25 - R1 was admitted to the facility with a diagnosis including Alzheimer's disease. 1/3/24 - A Brief Interview for Mental Status (BIMS) was completed for R1 and showed a score of 8 out of 15 indicating that the resident was moderately cognitively impaired. 1/13/25 11:57 AM - During an interview, E7 (CNA) stated that on 1/5/25 F1 reported to her that a staff member was being mean to R1. E7 further stated that R1 had stated that the staff was being rude. 1/13/25 12:56 PM - During an interview, E8 (Supervisor) stated that on 1/5/25 F1 reported to her that a staff member had said something to R1 that was not nice. E8 had F1 write a statement and then placed the statement under the door of E4 (SW), since it was the weekend. 1/13/25 1:16 PM - During an interview, E4 stated	F 609	b. All residents have the potential to be affected by this deficient practice. c. Root cause analysis was conducted, and it was found that staff did not follow the policy and procedure related to allegations of abuse and reviewing requirements related to reportable events. Staff Educator/Designee will re-educate facility staff on abuse policy and procedures to follow when there is an allegation of abuse. d. Grievances/concerns will be reviewed to ensure that any allegations of abuse are reported in a timely manner. Audits will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	

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F 609	Continued From page 3 that they saw the statement in her office on 1/6/25 and gave it to E3 (ADON). 1/13/25 1:56 PM - During an interview, E3 (ADON) did not know about a statement made from F1 regarding R1's accusation of abuse. 1/13/25 2:07 PM - During an interview, E1 (NHA) did not know about a statement made from F1 regarding R1's accusation of abuse. There was no evidence that the facility reported R1's allegation of abuse. 1/14/25 12:55 PM - Findings were reviewed during the exit conference with E1 and E2 (DON).	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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	F 610		3/3/25

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F 610	Continued From page 4 by: Based on interview, record review and review of other facility documentation, it was determined that for one (R1) out of three sampled residents for investigating an allegation of abuse, the facility failed to protect residents from abuse and investigate an allegation of abuse. Findings include: Cross refer to F609 The facility policy "Abuse, Neglect, Exploitation" last updated, May 2024 indicated, " ... An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur ...". Review of R1's clinical record revealed: 1/2/25 - R1 was admitted to the facility with diagnosis of Alzheimer's disease. 1/3/24 - A Brief Interview for Mental Status (BIMS) was completed for R1 and showed a score of 8 out of 15 indicating that the resident was moderately cognitively impaired. 1/13/25 11:43 AM - During an interview E6 (LPN) stated that on 1/5/25, F1 reported that a staff was inappropriate to R1. E6 stated that E8 (Supervisor) did not request that they write a statement. 1/13/25 11:57 AM - During an interview E7 (CNA) stated that on 1/5/25, F1 reported to her that a staff member was being mean to R1. E7 further stated that R1 had stated the staff was being rude. E7 reported this to E8 (Supervisor) and stated that E8 did not interview them or have	F 610	a. R1 has no adverse effect related to the deficiency. b. All residents have the potential to be affected by this deficient practice. c. Root cause analysis was conducted, and it was found that staff did not follow policy and procedure related to allegation of abuse investigation and reporting requirements. Staff Educator/designee will re-educate facility staff on abuse policy and procedures related to investigations. d. Grievances/concerns will be reviewed to ensure that any allegations of abuse are investigated promptly in order to protect residents from abuse and reporting requirements are met. Audits will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	

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F 610	Continued From page 5 them write a statement. 1/13/25 12:56 PM - During an interview E8 stated that on 1/5/25, F1 reported to her that a staff member had said something to R1 that was not nice. E8 had F1 write a statement and then placed the statement under the door of E4 (SW) since it was the weekend. E8 stated that she checked the facility schedule on the alleged date/time of the incident and did not find an employee who matched the description. 1/13/25 1:16 PM - During an interview, E4 stated that they saw the statement in her office on 1/6/25 and gave it to E3 (ADON). 1/14/25 12:09 PM - During an interview E1 (NHA) stated they did not know about the statement written by F1, it was not brought forward as a formal matter and that R1 was discharged the next day. 1/13/25 2:07 PM - During an interview, E1 (NHA) did not know about a statement made from F1 regarding R1's accusation of abuse and that an investigation should have been completed. There was no evidence that the facility investigated R1's allegation of abuse to the state agency 1/14/25 12:55 PM - Findings were reviewed during the exit conference with E1 and E2 (DON).	F 610		