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:** February 16, 2024

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201	**The State Report incorporates by reference and also cites the findings specified in the Federal Report.** An unannounced second Follow-up Survey to the Annual, Complaint, Emergency Preparedness and Extended Survey ending 9/25/23 was conducted by the State of Delaware Division of Health Care Quality, office of Long Term Care Residents Protection on February 14, 2024 through February 16, 2024. The facility census on the first day of the survey was one-hundred and twenty-four (124). The sample size was nineteen (19) residents.		
3201.1.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.2	**Scope** **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:		
Title 16	Cross Refer to the CMS 2567-L survey completed February 16, 2024: F684.		

Provider's Signature __Rebecca White_____Title_____LNHA_____Date _2/28/2024_____

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Part II Chapter 11 Subchapter VII § 1161	**Health and Safety** **Regulatory Provisions Concerning Public Health** **Long-Term Care Facilities and Services** **Minimum Staffing Levels for Residential Health Facilities** **Definitions.** **(f) "Nursing Supervisor" shall mean an advanced practice nurse or registered nurse who is assigned to supervise and evaluate nursing services direct caregivers no less than 25 percent of the nursing supervisor's time per shift. Up to 75 percent of the nursing supervisor's time per shift may be spent providing direct care... An individual serving as a nursing supervisor must be an employee of the facility, thus excluding temporary employment agency personnel from serving in this capacity unless exigent circumstances exist.** **This requirement was not met as evidenced by:** Review of the facility's Daily Schedule Report for Sunday, 2/4/24, revealed that E5 (LPN) was assigned the Full Building as Nursing Supervisor on 3 PM – 11 PM shift. 2/16/24 at 8:48 AM – During a telephone interview, E6 (agency RN) confirmed that E5 (LPN) was the assigned Nursing Supervisor on the 3 PM – 11 PM shift on 2/4/24. 2/16/24 at 9:50 AM – During a telephone interview, E7 (agency RN) confirmed that E5	**State Tag: Title 16, Chapter 11, Sub. 7 Minimum Staffing Levels** A.All residents have the potential to be affected by the deficient practice. B.A nursing schedule audit was conducted by NHA in coordination with the staffing scheduler for the current weekly scheduling period 2/18 to 2/24 and identified an RN was scheduled each shift but	3/2/2024

Provider's Signature __Rebecca White_____Title_____LNHA_____Date _2/28/2024_____

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	(LPN) was the assigned Nursing Supervisor on the 3 PM – 11 PM shift on 2/4/24. 2/16/24 at 11:13 AM – During a telephone interview, E5 confirmed that he was the assigned Nursing Supervisor on the 3 PM – 11 PM shift on 2/4/24. 2/16/24 at 2:00 PM – Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON) and E4 (VPO).	incorrectly scheduling of LPN as supervisor on night shifts. No residents were affected by the deficient practice. C.A root cause analysis determined a necessity to utilize Agency staff to fill licensed nursing positions. An in-house LPN who is more familiar with facility workflow was utilized for administrative duties. The facility did not notify DHCQ via the exigent circumstance reporting form of not having an inhouse RN acting in the role of supervisor. The facility is actively recruiting full time RN night shift supervisor. In the event a facility employed RN is unavailable and an Agency RN is utilized, the facility will notify the division utilizing the exigent circumstances reporting form. D.The DON/Designee and the staffing scheduler will meet daily to ensure a facility employed RN is scheduled on each shift as the supervisor for compliance 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	

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		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. E. Date of compliance: 3/2/2024	

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	085033	A. BUILDING _____ B. WING _____	R-C 02/16/2024

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}	INITIAL COMMENTS An unnanounced second Follow-up Survey to the Annual, Complaint, Emergency Preparedness and Extended Survey ending 9/25/23 was conducted by the State of Delaware Division of Health Care Quality, office of Long Term Care Residents Protection on February 14, 2024 through February 16, 2024. The facility census on the first day of the survey was one-hundred and twenty-four (124). The sample size was nineteen (19) residents. The facility was found to not be in substantial compliance with 42 CFR Part 483, Subpart B, Requirments for Long Term Care as of February 16, 2024. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing CNA - Certified Nurse's Aide; Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; DON - Director of Nursing; Facial pain scale - pain scale used for pain ratings that combines pictures and numbers; Grimacing - facial expression of pain; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; NP - Nurse Practitioner; Neurological assessment - examination that assesses vital signs and oxygen level, level of consciousness (includes verbal response), orientation to person, place and time, ability to open eyes, pupil check, speech, strength in upper and lower limbs and motor responses, such as withdrawal to touch and extension of limb(s);	{F 000}		

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

Electronically Signed | 02/28/2024

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.

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{F 000}	Continued From page 1 RN - Registered Nurse; Urine analysis - urine test to detect a urinary tract infection; VPO - Vice President of Operations.	{F 000}		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that R1's neurological (neuro) assessments were completed, including accurately and timely, after a fall on 2/4/24. In addition, the facility failed to ensure that R1 was monitored and not left alone after a noted change of condition and 911 emergency services was called. Finding included: 1a. The facility's policy and procedure for Neurological Assessment, dated 1/29/24, stated: " ... PROCEDURE: 1. Explain to the patient why neurological assessment is being performed. 2. Complete the Neurological Checklist Assessment in the medical record. Assess: a. Vital Signs b. Orientation c. Level of Consciousness d. Pupillary response e. Verbal responses f. Pain g. Movement and sensation of extremities	{F 684}	F684 Quality of Care A. R1 was readmitted from the hospital with no new acute diagnosis and is receiving rehabilitation services. B. B1. An audit of all residents with neurological assessments for the past 2 weeks was conducted to ensure all assessments are completed, accurate, and timely. Results determined that there were ongoing issues with the User Defined Neurological Assessments in Point Click Care and nursing staff did not follow the Neurologic Assessment policy correctly. No residents were negatively affected by the deficient practice. B2. An audit was conducted on all residents sent to the Hospital in the past two weeks, 5 residents were identified with no noted communication or monitoring concerns. No residents were	3/2/24

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{F 684}	Continued From page 2 3. Complete assessment every 15 minutes for the first hour, every 30 minutes for the next two hours, and every hour for the next four hours. 4. Continue monitoring if the assessment is abnormal. 5. Notify provider and responsible party of any abnormal findings. Document in the medical record and follow provider recommendations." R1's clinical record revealed: 7/21/23 - R1 was admitted to the facility with diagnosis that included, but was not limited to, dementia. 2/4/24 at 1:30 PM - The facility's incident report documented that R1 slid from her chair to the floor in her room. E8 (RN/day-shift Nursing Supervisor) assessed R1 with no visible injuries noted. R1 was unable to verbalize what had occurred and neuro assessments were initiated as evidenced by the following: - 1:15 PM neuro assessment by E8 - vital signs: 97.8 (temperature), 90 (pulse), 18 (respirations) 138/66 (blood pressure). - 1:30 PM neuro assessment by E8 - the same vital signs from the 1:15 PM assessment were listed when current vital signs were required. - 1:45 PM neuro assessment was not completed. - 2:00 PM neuro assessment was not completed. - 2:30 PM neuro assessment was not completed timely. Rather the assessment was completed by E9 (LPN) at 2:45 PM and listed the same vital signs from the 1:15 PM assessment when current vital signs were required. In addition, under the pain section, E9's assessment documented that R1 had verbal expressions of pain and non-verbal signs (grimaces, withdrawn), but then E9 checked the "No hurt" face under the facial pain	{F 684}	negatively affected by the deficient practice. C. C1.Root cause analysis determined that there were ongoing issues with the User Defined Neurological Assessments in Point Click Care and nursing staff did not follow the Neurologic Assessment policy correctly. The Neurological Assessment policy was reviewed and revised to accurately reflect nurse practice aligns with assessment. System change includes moving to the paper version of Neurological Assessment and uploading them to the resident miscellaneous tab in Electronic Health Records. This system change will better capture timing schedules of level of consciousness, vital signs, and pain. All licensed nurses will be trained in new processes on completion of neurological assessments. C2. Root cause analysis determined that the Emergency care policy did not identify staff roles and responsibilities. Emergency care procedure changed to include: " The DON/ADON/designee will be notified for all residents requiring emergency care. " The supervisor/designee will assign roles and responsibilities to ensure monitoring of residents, giving reports to EMS, generating clinical charts and guiding EMS to appropriate location. All licensed nurses will be trained in the revised Emergency care procedure. D. The DON/Designee will audit all residents needing neurological assessments/checks and residents being transferred to the hospital for compliance weekly x 4 weeks until 100%, then every 2	

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{F 684}	Continued From page 3 scale contradicting the two previous answers. - 3:00 PM neuro assessment was not completed. - 3:30 PM neuro assessment by E9 (LPN) - vital signs documented on this assessment were timed 4:00 PM and R1's pain section was documented the same way as the 2:30 PM neuro assessment. - 4:00 PM neuro assessment by E9 (LPN) - vital signs listed on this assessment were time 4:31 PM and 4:32 PM; and R1's pain section was documented the same way as the 2:30 PM and 3:30 PM assessments. - 5:00 PM assessment by E9 (LPN) - R1's pain section was documented the same way as the 2:30 PM, 3:30 PM and 4 PM assessments. - 6:00 PM assessment by E9 (LPN) - Under vital signs, temperature (98.2) was timed for 6 PM. However, R1's pulse, respirations and blood pressure were all timed at 7:36 PM. R1's pain section was documented the same way as the four previous assessments timed (2:30 PM, 3:30 PM, 4 PM and 5 PM). - 7:00 PM assessment by E6 (agency RN) - R1 had no verbal expressions or non-verbal signs of pain. The facility failed to complete three (3) neuro assessments at 1:45 PM, 2 PM and 3 PM; failed to complete the 2:30 PM assessment timely; failed to accurately capture current vital signs on five (5) assessments (1:30 PM, 2:30 PM, 3:30 PM, 4 PM and 6 PM); and failed to accurately capture R1's pain on five (5) assessments (2:30 PM, 3:30 PM, 4 PM, 5 PM and 6 PM). 2/15/24 at 2:30 PM - During an interview, E9 (LPN) stated that she made a mistake under the pain section in her neuro assessments by checking that R1 had both verbal and non-verbal	{F 684}	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. E. Date of compliance: 3/2/2024	

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{F 684}	Continued From page 4	{F 684}		

signs of pain. E9 stated that R1 had no pain when she performed the neuro checks.

2/16/24 at 8:48 AM - During an interview, E6 (agency RN) stated that she was R1's assigned nurse on the 3 PM - 11 PM shift. E6 stated that this was the first time working in the facility since last October 2023 and E9 (LPN) offered to continue to complete R1's neuro assessments despite being assigned to another hallway as E9 was working an extra shift as a CNA. E6 stated that she performed the 7 PM neuro assessment.

1b. On 2/4/24 at 6 PM - A nursing note documented by E6 (agency RN) that "...Patient (R1) was found lying on the bed with no distress. Patient awake/alert able to answer questions appropriately. Right cheek slightly swollen. Vital signs stable... Neuro checks WNL (within normal limits) (sic) Moves all extremities. Patient is unable to communicate if she is in pain 2nd (secondary) to Dementia... New order for (urine analysis and labs)."

On 2/4/24 at 6:15 PM - A nursing note documented by E5 (LPN/Nursing Supervisor) that R1's family member complained that R1 "might be having facial drooping, RN (agency E6) assessed resident... NP (Nurse Practitioner) on call notified."

2/4/24 at 6:23 PM - A nursing note documented by E5 (LPN/Nursing Supervisor) that the NP on call was notified of the family member's complaint and the RN assessment... NP on call order (sic) (labs and urine analysis)."

Despite being assessed by E6, E5 requested the other agency RN (E7) in the building who was

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{F 684}	Continued From page 5 assigned a medication cart on the second floor to come down and assess R1. E7's assessment was documented in a nursing note as: "... Change of Condition... Was called to patient's room to assess patient due to questionable change in mental status and s/p (status post) fall on 2/4. Patient was seen in bed lying on bed; patient has communication deficit which is noted in medical records. Patient was not able to participate in neuro assessment; unable to smile, stick out tongue or raise arms. Patient is unable to communicate if she is in pain. Upon applying light pressure to bilateral hips, patient grimacing and moved her arms to her sides. Patient was guarded. Patient overall assessment was limited. Primary provider was notified for further interventions." 2/4/24 at 6:40 PM - A nursing note by E5 (LPN/Nursing Supervisor) documented that R1 "has a facial L (left) infraorbital (location beneath the eye) lump, resident could not follow instructions to assess neuros. Resident flinched during pain assessment when hip was touched... This writer recommend (sic) resident sent out to get a CAT scan (diagnostic test)... Awaiting NP orders, message left for answering machine." 2/4/24 at 7:00 PM - A nursing note by E5 (LPN/Nursing Supervisor) documented that "per RN assessment... this writer notified NP of RN (E7) recommendations. NP order (sic) resident to be sent to the hospital...". According to the Prehospital Care Report, the sequence of events were captured as follows: -at 7:34 PM, 911 received call from the facility. -at 7:36 PM, BLS (Basic Life Support) unit was dispatched to the facility for a fall.	{F 684}		

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{F 684}	Continued From page 6 -at 7:46 PM, BLS was at the patient's bedside. -at 8:01 PM, BLS departed the facility. The Report documented that R1 "was responsive to painful and verbal stimuli. The nurse was out in the hallway passing medications to other patients. This crew went over to nurse and stated that we needed a report given to us and we asked what was going on with the patient and she told us to wait (sic) she continue to do what she was doing and did not come into the bedside to give report. After approximately another five minutes went by ambulance crew again, went down to track down a staff member and they all stated that it was another person's responsibility. Then the original nurse started to try to gather paperwork, but still hadn't come to give report when another five minutes went by BLS crew went to get a staff member again and that's when she handed us the paperwork to the patient and stated she didn't know what was going on with the patient... she fell at 1 PM today she did not get on shift till 3 PM and she's not exactly sure what's going on with the patient and why they are acting the way she is... Due to the patient's potential change in mental status after fall, and the nursing staff, not knowing if she was on blood thinners, or if she lost consciousness, or if she hit her head a trauma eval (evaluation) was requested while in route to (name) hospital...". 2/5/24 at 4:13 PM - The hospital's neurology consult documented that R1 was seen for a "fall and transient facial droop" and subsequently ruled out an acute stroke. 2/9/24 - In the facility's five-day follow-up investigation of R1's fall on 2/4/24 at approximately 1 PM, the following statements were obtained:	{F 684}		

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{F 684}	Continued From page 7 - E6's (agency RN) telephone statement documented that R1's "family was saying she (R1) doesn't look ok... The family said there was a facial droop and I did not see a facial droop, but I did see some swelling... this was about 6:00 PM...". - E5's (LPN/Nursing Supervisor) statement documented that E5 "... got a call from the (family member)... said something about (R1) maybe having a facial droop... It was about 6:00 PM... (R1) was answering more slowly but wasn't making sense. (R1) will usually make sense when she answers, but now (R1) was not making sense...". - E7 (agency RN) statement documented that during her assessment around 7 PM R1 "...did not have a facial droop...". 2/15/23 at 3:30 PM - During an interview, A1 (BLS crew member) stated that they were dispatched to the facility for a fall. When BLS arrived at the patient's bedside, A1 stated that there was no staff member in R1's room monitoring her and ready to give verbal report. A1 stated that BLS asked for information about recent medication changes and history. A1 stated that they were handed paperwork. A1 stated that the nurse said that she did not know what was going on with the resident and the nurse would not give her name to BLS personnel. A1 also stated that the Nursing Supervisor was sitting at the nursing station desk. 2/16/24 at 8:48 AM - During an interview, E6 (agency RN) stated it was her first time back in the building since October 2023. E6 stated that she was R1's assigned nurse, but E9 (LPN) would continue performing R1's neuro checks until 6 PM (It should be noted that E9 was	{F 684}		

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{F 684}	Continued From page 8	{F 684}		

assigned to work on another hallway during the 3-11 PM shift). E6 stated that R1's family came in and said that R1 doesn't look right. E6 stated that she observed the eye swelling, but no facial droop. E6 stated that E5 told her that R1 was being sent out to the hospital. E6 stated that she told the (BLS crew member) that she was in the middle of doing something for another patient and she would be right there. E6 stated that she wasn't in R1's room the whole time when (BLS) were there and that one (BLS crew member) was very upset and rude. E6 stated that she was looking for an envelope to put R1's paperwork in to give to them.

2/16/24 at 9:50 AM - During an interview, E7 (agency RN) stated that she was working on the second floor on a medication cart during the 3 PM - 11 PM shift on 2/4/24. E7 stated that she was on break at the time when E5 (LPN/Nursing Supervisor) asked her to assess R1 because the resident had a fall and the family was upset. E7 stated that when E5 told her that the "(BLS crew) were going to report us to the State, she asked if someone was with R1 when they arrived? He said no. E7 said well that's why. Someone has to stay with the resident."

2/16/24 at 10:53 AM - During an interview, E10 (CNA) stated that when one of the (BLS crew members) came out of R1's room, he "looked pissed." E10 said that the (BLS crew member) was very upset that nobody was in there with R1.

2/16/24 at 11:13 AM - During an interview, E5 (LPN/Nursing Supervisor) stated that he wanted a second opinion on R1's neuro assessment and asked E7 (RN) from upstairs to conduct another assessment. Based on E7's assessment 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 _____	R-C 02/16/2024

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 684}	Continued From page 9 discussion with the NP on call, E5 called 911 to have R1 sent to the hospital for further evaluation. E5 stated that he was preparing the paperwork while E6 (assigned agency RN) was monitoring R1. E5 stated he was not sure if E6 was in the room with R1. E5 stated that it took some time to generate the paperwork for the BLS personnel. E5 stated that E6 should have given report to the BLS personnel. E5 stated that one of the (BLS crew members) was upset and he tried to talk to him about his concerns as he was leaving. 2/16/24 at 2:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON) and E4 (VPO)	{F 684}		