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: Pike Creek Nursing and Rehabilitation

DATE SURVEY COMPLETED: May 19, 2026

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 May 13, 2026, through May 19, 2026. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents, as indicated. The facility census for the first day of the survey was one hundred sixty-two (162). The survey sample totaled thirty (30) 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 was not met as evidenced by: Cross Refer to the CMS 2567 – L survey completed May 19, 2026: cross refer: F684 and F689.	Please refer to Pike Creek Nursing and Rehabilitation Plan of Correction on CMS 2567 for F684 and F689.	6/19/26

Provider's Signature Brian A. Lenton Title Administrator Date 6/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085033	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD , WILMINGTON, Delaware, 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
F0000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from May 13, 2026, through May 19, 2026. The deficiencies contained in this report are based on interviews, observations, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was one hundred sixty-two (162). The sample size was thirty (30) Abbreviations and Definitions: ADON - Assistant Director of Nursing; BIMS - Basic Inventory of Mental status, a structured assessment tool aimed at evaluating cognition in the elderly. BIMS score of 0-7 is reflective of severe cognition deficit, 8-12 reflects moderate cognition deficit and 13-15 score is reflective of normal cognition; CNA - Certified Nurse's Aide; Compression Fracture - collapse of a vertebra that may be due to trauma or due to weakening of the vertebra due to other conditions; DON - Director of Nursing; LPN - Licensed Practical Nurse; MD - Medical Director; MDS - Minimum Data Set/a federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; NHA - Nursing Home Administrator; OT - Occupational Therapist; RN - Registered Nurse; SD - Staff Development.	F0000		06/02/2026

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

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

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F0684 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 observation, interview, record review and review of other facility documentation, it was determined that for two (R29 and R30) out of three residents sampled for quality of care, the facility failed to ensure that R29 and R30 were assessed by a Registered Nurse after it was identified that they had fallen to the floor. The facility also failed to ensure that the post fall documentation was completed, and the physician and responsible parties were notified in a timely manner. Due to the facility's corrective measures completed on 5/11/26, the facility was notified that R29's and R30's incidents were past non-compliance. Findings include: 1. R29's clinical record revealed: 3/26/26 – R29 was admitted to the facility with diagnoses including, but not limited to, right shoulder fracture and lung cancer. 4/4/26 – R29's MDS assessment documented a BIMS score of 15, indicating a fully intact cognitive status. The assessment also documented that R29 required the assistance of one staff member for transfers. 5/7/26 3:23 PM – A facility incident report submitted to the Division included, "... The resident [R29] told the therapy staff that she sat on the floor this morning and scooted to the call bell and rang and someone helped her up.... She stated a nice gentleman, and a lady picked her up." 5/19/26 9:30 AM – During a telephone interview, E7 (CNA) stated, "I saw her [R29] sitting on the floor near her bed. I held her hand and helped her back to her bed." The Surveyor asked E7 if nurse was informed that the resident was found sitting on the floor. E7 stated, "No, I forgot to tell the nurse."	F0684	"Past Noncompliance - no plan of correction required"	06/02/2026

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F0684 SS = D	Continued from page 2 5/19/26 10:00 AM – A review of R29's clinical record lacked evidence of a post-fall assessment by a Registered Nurse for possible injuries after she was found sitting on the floor and before being moved by the CNA. 2. R30's clinical record revealed: 4/29/26 – R30 was admitted to the facility with diagnoses including, but not limited to, Parkinson's disease and acute pain due to trauma. 5/6/26 – R30's MDS assessment documented a BIMS score of 13, indicating a mild cognitive impairment, and was dependent on staff for all transfers. 5/7/26 12:00 PM – A facility incident report submitted to the Division included, "... An anonymous note was received by the HR (Human Resources) Office alleging that [R30] had fallen on 5/5/26 and the fall went unreported." The facility's investigation revealed that the incident had occurred on 5/6/26 at approximately 6:30 AM. 5/19/26 12:30 PM – During a telephone interview, E8 (CNA) stated, "I was passing by the room, and I saw the resident [R30] on the floor in a kneeling position on the side of his bed. His hands were on the bed like he was trying to get himself back up. I saw his aide [E9 CNA] in the hallway and told her that the resident was on the floor. I then saw the nurse [E10 LPN] and the aide [E9] in the hallway and told them that he was on the floor. They went into his room." The Surveyor asked E8 how she became aware that the fall was not reported. E8 stated, "Because no one asked me for a statement about the fall." 5/19/26 12:45 PM – During a telephone interview, E9 stated, "The nurse [E10] and I went into the room and saw the resident kneeling on the side of the bed. We helped him back into his bed." The Surveyor asked E9 whether a nursing assessment had been completed before R30 was helped back to his bed. E9 stated, "No, we just put him back to bed." 5/19/26 1:00 PM – The Surveyor left a telephone message for E10 requesting a return call. E10 did not call back while the survey was in progress. 5/19/26 1:30 PM – During an interview, E1 (NHA) and E3 (DON) stated that they were aware that R29 and R30's falls were not reported, the post-fall assessments, physician and family notification, and	F0684		06/02/2026

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F0684 SS = D	Continued from page 3 documentation were not being completed, and they immediately began a plan of correction. 5/19/26 2:00 PM – The facility provided the Surveyor the following information: a. The staff members who did not report the falls received disciplinary action and education on reporting falls. b. Falls for the past 2 weeks were reviewed to ensure that they have the risk management report and required documentation completed. c. A Quality Assurance meeting was held to address physician and responsible party notification, and education started for all staff related to reporting falls, documentation required to include a risk management report at the time of the fall. RN fall documentation, post-fall investigation, and fall risk scoring tool. d. The DON/designee will audit all falls to ensure the required assessments and documentation are completed, and if necessary, reported to the proper State Agency. These audits will be completed daily x 5 days, then weekly x 3 weeks, and then monthly x 2 weeks. The results will be brought to QAPI for review and follow-up as needed. 5/19/26 2:15 PM – The Surveyor conducted record review, and staff interviews, and the plan of correction was verified. 5/19/26 3:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the Exit Conference.	F0684		06/02/2026
F0689 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:	F0689	F-689 The facility is unable to retroactively correct the observation for Residents R2 as this is a past event. Resident was assessed after the fall and no injuries were noted. Resident has leg rests present in room. Residents utilizing wheelchairs for mobility have the potential to be affected. An audit was conducted by Rehab Program Director and QA Nurse to ensure in-house residents utilizing wheel chairs have foot rests. Education provided to staff (see below). Root cause of deficiency determined to be staff not following facility procedure and education needed on	06/19/2026

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F0689 SS = D	Continued from page 4 Based on observation, interview, record review and review of other facility documentation, it was determined that for one (R2) out of three residents sampled for accidents, it was determined that the facility failed to ensure that R2 received adequate supervision and assistive devices to prevent accidents to the extent possible. Findings include: 1/29/24 – A facility document entitled, "Falls Management Program", included, "A fall is defined as an unintentional change in elevation coming to rest on the ground or onto the next lower surface (e.g. onto a bed, chair or bedside mat.) An episode where a patient would have fallen, if not for staff intervention, is considered a fall." R2's clinical record revealed: 11/25/25 – R2 was admitted to the facility with diagnoses including, but not limited to, congestive heart failure and chronic arterial ulcer of the right foot. 2/24/26 – R2's quarterly MDS assessment documented a BIMS score of 11, indicating a moderately impaired cognitive status (decisions poor; cues/supervision required). The MDS also documented that R2 was dependent on staff for wheelchair mobility. 11/26/26 – R2's fall care plan included, "…At risk for falls related to poor balance…" 4/19/26 11:15 AM – R2's nursing progress note included, "… Per CNA assigned to the resident, the resident fell while being helped out of the bathroom back to her room. The resident was sitting in her w/c [wheelchair], and the CNA was behind her. Resident was requested to put her legs up while sitting on her w/c, and all of a sudden, before she could even do it, she fell." 5/19/26 9:15 AM – During an interview, R2 stated, "I had just finished in the bathroom, and the girl [CNA] was wheeling me back to my room, and I fell forward out of the chair. I am glad I was not hurt." The Surveyor asked R2 whether the foot pedals were on the wheelchair when she was in the wheelchair. R2 stated, "No." 5/19/26 10:00 AM – During an interview, the Surveyor asked E6 (OT) whether R2 could keep her lower extremities elevated during transportation with the wheelchair. E6 stated, "No. [R2] is dependent on wheelchair mobility."	F0689	Continued from page 4 the use of wheelchair leg rests when transporting residents. Staff Development Coordinator or Shift Supervisors will educate employees in all departments on use of wheelchair footrests when transporting residents in wheelchairs. Daily audits will be conducted daily by Administrator, DON or ADON, and Shift Supervisors to ensure all residents being pushed in wheelchairs have leg rests. Audits will include at least 15 total residents per audit. Daily Audits will continue until two consecutive weeks of 100% compliance are achieved at which time the audits will be conducted three times per week for two weeks. Once these audits demonstrate 100% compliance for two consecutive weeks, the audits will be conducted weekly and end once four consecutive weeks of 100% compliance are achieved. Audits will be brought to the QAPI Committee for further review and recommendations. Date of Compliance – 6/19/26	06/19/2026

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F0689 SS = D	Continued from page 5 5/19/26 11:00 AM – The facility's investigation included, "The CNA stated she was going to take the resident back to bed. She requested the resident lift her legs and feet, and the resident fell forward out of the wheelchair". The facility failed to ensure that R2 was free from accidents when she fell while she was transported in a wheelchair without footrests. 5/19/26 3:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the Exit Conference.	F0689		06/19/2026