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: Cadia Rehabilitation Pike Creek

DATE SURVEY COMPLETED: July 1, 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 June 16, 2026, through July 1, 2025. The deficiencies contained in this report are based on observations, interviews, reviews of residents' clinical records, and reviews of other facility documentation as indicated. The facility census on the first day of the survey was (one hundred fifty-five) 155. The investigative sample totaled (4) four 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 July 1, 2026: cross refer: F609 and F689.	Cross Refer to the CMS 2567-L survey completed July 1, 2026: cross refer: F609 and 689.	8/3/2026

Provider's Signature Brandi Wilson Title LNHA Date 7/16/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	**3540 THREE LITTLE BAKERS BLVD , 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 beginning June 15, 2026. The deficiencies in this report are based on observations, interviews, reviews of residents' clinical records, and reviews of other facility documentation, as indicated. The facility census on the first day of the survey was 155. The investigative sample totaled four residents. Abbreviations/definitions used in this report are as follows: Cerebrovascular disease: A problem with the blood vessels in the brain; CNA - Certified Nursing Assistant; DON - Director of Nursing; FM - Family Member; NHA - Nursing Home Administrator; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 - 15. 13 - 15: Cognitively intact. 8 -12: Moderately impaired. 0 - 7: Severe impairment; Hemiplegia: Complete paralysis of one side of the body; Hemiparesis: Weakness on one side of the body;Hoyer Lift – sling-type hydraulic lift; MDS assessment- federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs.	F0000		07/09/2026
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F0689	"Past Noncompliance - no plan of correction required"	07/09/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	**3540 THREE LITTLE BAKERS BLVD , 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
F0689 SS = SQC-J	Continued from page 1 §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 observation, interview, and record review, it was determined that for two (R1and R2) out of three residents reviewed for accident hazards and falls, the facility failed to ensure that R1 and R2 received adequate assistance and supervision to prevent falls to the extent possible. R1, a cognitively impaired and completely dependent resident, sustained a fall on 6/9/26 at 4:15 PM when a staff member used an incorrect mechanical lift and sling to perform a transfer from the wheelchair to the bed. This fall caused R1 to suffer a hematoma to the front of her head, and she was sent emergently to the hospital. R1 was diagnosed with multiple brain bleeds and skull fractures. Due to this failure, an Immediate Jeopardy (IJ) was called at 9: 00 AM on 6/16/26. For R2, a resident who required two staff members' assistance with bed mobility, was repositioned in the bed with one person's assistance. R2 fell from the bed to the floor and was sent emergently to the hospital. Based on review of the facility's evidence to correct the deficient practice and substantial compliance at the time of the current survey, the deficiency was determined to be past non-compliance as of 6/12/26 with an abatement date of 6/16/26. Findings include: A facility document entitled "Fall Assessment, Prevention and Management", dated 6/2006 and revised 1/20/23 and 1/13/26, included, "It is the policy of (name of facility) to assess for fall risks and implement measures to prevent and manage the identified risks." 1. R1's clinical records revealed: 12/19/23 – R1 was admitted to the facility with diagnoses including but not limited to dementia, stroke, and end-stage kidney disease. 4/28/26 – R1' s transfer care plan included, "Resident [R1] requires Hoyer lift for transfers (Assist of 2)".	F0689		07/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD , 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
F0689 SS = SQC-J	Continued from page 2 5/28/26 – R1's annual MDS assessment documented a BIMS score of "00," indicating a severely impaired cognitive status. R1 was completely dependent on staff for all transfers between surfaces. 6/9/26 4:20 PM – R1's clinical documentation included, "...Called to the resident's room and saw the resident lying on the floor. The resident slipped out of the Hoyer lift during transfer. The resident was assessed by the NP, and a bump on the back of her head was noted. Husband present and asked for her to be assessed at the ER [emergency room]. 911 was called..." 6/9/26 5:26 PM – A facility reported incident submitted to the Division documented, "Resident transferred to the ED [emergency department] s/p [status post] related to contusion to posterior head." 6/15/26 1:20 PM – During an interview, E4 (CNA) stated, "I answered the call bell and saw the resident sitting in the wheelchair in her room. Her husband [F1] asked me to put her to bed. I got the Hoyer lift and the sling. I placed the sling under the resident and hooked it up to the lift. I started to raise the lift, and the resident fell to the floor. I went and got the nurse." The Surveyor asked E4 how long he had been a CNA and if he had worked with R1 prior to the fall. E4 stated, "I have been a CNA for three months, and this is my first job. This was the first time I was working with this resident." The Surveyor then asked E4 how he knew what R1's transfer was and what equipment was needed for the transfer. E4 stated, "I checked her transfer status in the closet and saw that she needed a Hoyer lift. I went out to the hallway and saw the lift, but there was no sling attached to it. I got a sling from the storage room. I didn't know that sling was not the correct one for that lift". E4 used a Hoyer lift and a sling to demonstrate how he attached the sling to the lift. The Surveyor then asked E4 whether he knew that two staff members were needed for a Hoyer lift for transfers. E2 stated, "Yes." 6/15/26 2:15 PM – During a telephone interview, F1 stated, "We had just returned from an appointment, and my wife wanted to go to bed because she was tired. I rang the call, and the aide came into the room. He put the sling under her and hooked it up to the lift. He began to raise the lift, and she fell to the floor. She fell and cracked her head. She is in the hospital with multiple brain bleeds and skull fractures. She is not a candidate for surgery and is not expected to recover. We are planning to meet	F0689		07/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	**3540 THREE LITTLE BAKERS BLVD , 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
F0689 SS = SQC-J	Continued from page 3 with the hospice to discuss end-of-life care." 6/16/26 10:00 AM – During an interview, E2 (DON) stated, "The facility has two types of Hoyer lifts, and they use two different types of slings. One of the slings snaps into place, and the other one hooks into place on the lifts. Our investigation revealed that [name of CNA] did not use the correct sling for the lift that he used to transfer the resident. He used the one that hooks on the lift rather than the one that snaps into place. I was in the facility when the resident fell, and I went to the unit to assess her. I saw that she was lying on the floor with the sling under her body. The investigation also revealed that a second staff member was not present during the transfer. I immediately provided education to him about having two staff members for Hoyer lift transfers and using the correct slings and lifts. I put pictures of the slings and other information on the lifts to show what types of slings should be used on the specific lifts. I began education for all other staff as well." The Surveyor observed the lifts with pictures of slings on them. The facility failed to use the appropriate sling for the Hoyer lift and to have the required two staff members for R1 during the transfer from the wheelchair to bed. R1 sustained a traumatic fall which resulted in multiple brain bleeds and skull fractures. The facility's action plan included: Like residents who require a mechanical lift for transfers were identified to ensure the transfer status order is in place. DON completed a random audit of residents on 6/9/26 with no further deficient practice identified. A review of risk management for 90 days was completed to validate that no additional fall incidents related to mechanical lift transfers occurred, with no additional incidents identified. A full review of all residents' care plans requiring two-person assistance for transfers. The CNA involved was immediately removed from the floor and in-serviced by the rehabilitation director.	F0689		07/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD , 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
F0689 SS = SQC-J	Continued from page 4 The facility immediately initiated education with certified nursing assistants on 6/9/26. Facility attached laminated photos to each mechanical lift to show the correct type of sling based on the lift in use. The facility began audits of mechanical lift transfers to validate the proper level of staff assistance and ensure that the correct sling is utilized for the lifts. The facility is conducting ongoing audits to monitor compliance. The facility will continue audits 3 times a week for one week or until 100% compliance is reached, then weekly for 3 weeks until 100% compliance is reached, and then monthly for 1 month until 100% compliance is reached. The facility QAPI committee will review the results of the observations made by the DON/designee to identify any trends/conduct root cause analysis, and develop a plan of action for follow-up and resolution if necessary. 6/17/25 1:00 PM – Based on the Surveyor's review of the facility's investigation, documented response, completion of audits from 6/9/26 to 6/12/26, staff interviews, and no further falls or injuries from the mechanical lift, the IJ was considered past non-compliance with a compliance date of 6/12/26 at 5:30 PM. The IJ was abated on 6/16/26 at 1:00 PM. 2. R2's clinical record revealed: 8/25/23- Resident (R[2]) admitted to the facility with diagnoses including, but not limited to, hemiplegia (paralysis of one side of the body) & hemiparesis (weakness on one side of the body) following unspecified cerebrovascular disease (a problem with the blood vessels in the brain) affecting the left side of the body. 4/6/26- R2 had an order stating "Transfer: Hoyer lift (assist of 2); Bed Mobility (side to side): Assist of 2; left bed enabler to assist with bed mobility;	F0689		07/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD , 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
F0689 SS = SQC-J	Continued from page 5 Ambulation: N/A". 5/27/26- The most recent quarterly MDS documents R2's BIMS score as 14, indicating she is cognitively intact. The MDS also documented that R2 is dependent on staff for hygiene, bathing, toileting, and activities. 5/31/26 5:15 AM- A facility incident report submitted to the Division stated "Resident with witnessed fall from bed while receiving ADL care...Transferred to ED for clinical follow-up." 6/16/26 11:30 AM- During an interview, E5 (CNA) stated, "I was performing toileting and bowel clean up on R2. I knew she was a 2-person assist, but I was the only CNA on the unit during this shift. I have worked with R2 before, and I am usually able to handle her on my own. While I was tolieting R2, she rolled away from me on the bed. I was unable to catch her, and she fell to the floor." E5 confirmed that she was the only facility staff member present during this encounter. 6/16/26 12:00 PM- A review of the facility's investigative document revealed that E5 performed toileting care on R2 without the assistance of another staff member present. The facility failed to ensure that R2 was free from accidents when she fell from her bed while receiving care. 6/17/25 1:00 PM – Based on the Surveyor's review of the facility's investigation, documented response, completion of audits, staff interviews, and no further falls or injuries, the second example was considered past non-compliance with a compliance date of 6/12/26 at 5:30 PM. The IJ was abated on 6/16/25 at 1:00 PM. 6/16/26 1:30 PM – Findings were reviewed at the exit conference with E1 (NHA), E2 (DON), and E3 (COO).	F0689		07/09/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse,	F0609	1. The facility is unable to correct this deficient practice as R1 no longer resides in the facility. 2. All residents who sustain an incident involving injury have the potential to be affected by this	08/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085054	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD , 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
F0609 SS = D	Continued from page 6 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 record review and interview, it was determined that for one (R1) out of three residents reviewed for reporting of alleged violations, the facility failed to identify and report an allegation of neglect. The facility submitted a State reportable incident for a fall with injury and failed to acknowledge the actual allegation of neglect when a staff person transferred a resident incorrectly, resulting in a fall with significant injury. Finding include: R1's clinical records revealed: 12/19/23 – R1 was admitted to the facility with diagnoses including but not limited to dementia, stroke, and end-stage kidney disease. 4/28/26 – R1' s care plan included, "Resident [R1] requires Hoyer lift for transfers (Assist of 2)". 5/28/26 – R1's annual MDS assessment documented a BIMS score of "00," indicating R1 is unable to complete the cognitive assessment. R1 was completely dependent on staff for all transfers	F0609	Continued from page 6 deficient practice. The Director of Nursing and Corporate Clinical Nurse reviewed all reportable incidents occurring within the previous ninety (90) days to determine whether any incidents involving resident injuries, transfer errors, care deviations, or staff actions should have been classified and reported as allegations of neglect. Further residents will be protected by this deficient practice by measures outlined in Section 3. 3. Root cause analysis was conducted and revealed that the Director of Nursing failed to ensure that incident involving R1 was identified as an allegation of neglect related to a knowledge deficit. The Corporate Clinical Nurse educated the Administrator, Director of Nursing, Nurse Managers, and Nursing Supervisors regarding: Federal and State requirements for reporting alleged violations. Recognition of circumstances that may constitute an allegation of neglect. The requirement to report alleged violations immediately, but no later than two (2) hours when abuse is alleged or serious bodily injury has occurred, or within twenty-four (24) hours when applicable. The requirement to report allegations based on the known facts at the time of the event, regardless of whether the allegation is ultimately substantiated. Documentation requirements and completion of investigations, including submission of investigative findings within five (5) working days. In addition to the education, reportable incidents will be reviewed by the corporate clinical team prior to initial submission to determine the incident is reported under the proper category, as well as to review for possible neglect. 4. The Corporate Clinical Staff will audit 100% of resident incidents involving injury, hospitalization, staff error, deviation from a resident's plan of care, injuries of unknown source, or any circumstance	08/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085054	A. BUILDING B. WING	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD , 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
F0609 SS = D	Continued from page 7 between surfaces. 6/9/26 4:15 PM- Per facility investigation, E2 observed R1 lying on the floor with the sling underneath her; CNA reported the resident and sling fell from the Hoyer lift during transfer. RN/NP assessed the resident, noted a bump to the posterior head, and the resident's husband requested transfer to the ED; 911/ED transfer initiated. 6/9/26 4:20 PM – R1's clinical documentation included, "…Called to the resident's room and saw the resident lying on the floor. The resident slipped out of the Hoyer lift during transfer. The resident was assessed by the NP, who noted a bump on the back of her head. Husband present and asked for her to be assessed at the ER [emergency room]. 911 was called…" 6/9/26 5:26 PM – A facility reported incident submitted, via the State reporting system, to the Division documented, "Fall with Injury", "Resident transferred to the ED [emergency department] s/p [status post] related to contusion to posterior head." 6/16/26 10:25 AM - During an interview, E2 (DON) stated, "I was in the resident's (R1) room immediately after the incident occurred. I knew that the CNA used the wrong sling for the wrong Hoyer lift and that he did not have a second staff member present during the transfer". Although E1 (NHA) and E2 were aware of the actual circumstances of the fall immediately after the incident, the incident report remained vague and did not disclose the known transfer error, lack of required two-person assist, or the unsafe staff action contributing to the event that should have been identified as an allegation of neglect.	F0609	Continued from page 7 that may constitute neglect to ensure State reporting is completed as appropriate. Audits will be completed for 3 observations daily for 3 days or until 100% compliance is achieved, then 3 observations weekly for 3 weeks or until 100% compliance is achieved, then monthly for 3 months or until 100% compliance is achieved. Results of audits will be reviewed in the Quality Assurance and Performance Improvement (QAPI) meeting quarterly. Additional education or corrective action will be implemented as indicated.	08/03/2026