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:** August 26, 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. A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care Quality. The facility was found to not be in substantial compliance with 42 CFR 483. Survey Dates: 08/23/26 to 08/26/26 Survey Census: 165 Sample Size: 42 Supplemental Residents: 12		
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 August 26, 2026: cross refer: F552, F600, F605, F609, F641, F657, F809, F812, F880 and F881.	Please see plans of correction on CMS 2567-L for F-552, F-600, F-605, F-609, F-641, F-657, F-809, F-812, F-880 and F-881.	10/6/2026

Provider's Signature _____ Title LNHA Date 9/18/2026

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 08/26/2026

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
E0000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality, on 08/23/26 to 08/26/26. The facility was found to be in compliance with 42 CFR 483.73.	E0000		09/10/2026
F0000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care Quality. The facility was found to not be in substantial compliance with 42 CFR 483. Survey Dates: 08/23/26 to 08/26/26 Survey Census: 165 Sample Size: 42 Supplemental Residents: 12	F0000		09/10/2026
F0809 SS = F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.	F0809	F0809 - Intervals between meals Facility is unable to retroactively correct this incident as it occurred in the past. All residents receiving facility meals have the potential to be affected. Upon discovery, facility implemented system for Dietary Director to communicate staffing levels for the kitchen to the Administrator daily at Stand-up meeting and Stand-down meeting or by email, for the day of the communication and the day following the communication to ensure adequate staffing levels and/or plan to ensure adequate staffing levels. On Fridays, the schedule for the whole weekend and Monday will be reviewed by the Administrator and Food Services Director and the Food Services Director will communicate any changes to the Administrator as they occur so a plan can be made	10/06/2026

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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F0809 SS = F	Continued from page 1 §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, document review, record review, and policy review, the facility failed to ensure residents received meals at established mealtimes and regular intervals for residents receiving meals prepared by the dietary department. This deficient practice had the potential to affect 163 of 165 residents who received facility-prepared meals. As a result of this deficient practice, residents were at risk for hunger, discomfort, delayed nutritional intake, and unmet nutritional needs due to recurring delays in meal service. Findings include: Observation on 08/23/26 at 10:26 AM revealed facility staff delivered the breakfast food cart to the Bethany unit, and residents received breakfast trays nearly two hours after the scheduled breakfast service period of 7:30 AM to 8:30 AM had ended. During an interview on 08/23/26 at 10:30 AM, Cook 1 stated breakfast service was delayed because dietary staff either arrived late or failed to report to work. Cook 1 stated he arrived at 5:30 AM and that dietary staff scheduled to begin work at 6:30 AM did not arrive until after 7:00 AM. Review of the facility document titled "Tray Cart Delivery Sign Off" indicated the Bethany unit was scheduled to receive the breakfast cart at 8:30 AM. The document indicated breakfast was scheduled from 7:30 AM to 8:30 AM, lunch from 11:50 AM to 12:50 PM, and dinner from 5:00 PM to 6:15 PM. Observation on 08/23/26 at 12:25 PM revealed facility staff had not yet served lunch to residents on the Bethany unit. During an interview on 08/23/26 at 12:28 PM, a staff member who identified herself as an Assistant Manager employed by the facility's contracted dietary services company confirmed staff call-offs delayed breakfast service and continued to affect lunch service.	F0809	Continued from page 1 to reach required staffing levels. Food Services Director submits meal delivery logs to Administrator daily. Regional Food Services Director educated Facility Food Services Director on policy and procedure for ensuring meals are delivered on time and in accordance with regulations regarding timing between meals and on policy for staffing levels for the kitchen and communicating challenges with staffing levels to the Administrator as they occur. Regional Food Services Director, Food Services Director and Administrator established appropriate staffing levels per meal (breakfast, lunch and dinner) for the kitchen team to ensure meals can be delivered on time. Food Services Director educated Dietary Staff on process for ensuring all meals are delivered on time to all residents and on communicating staffing challenges to Food Services Director on meals/shifts the Food Services Director is not present on site. Administrator educated facility management team on which positions can be called upon to assist in the kitchen in the event of staffing challenges, and how non-dietary staff can assist dietary-staff to ensure meals are delivered on time (i.e. assisting to push carts from the kitchen to the nursing units so the kitchen staff can remain in the kitchen to complete the tray-line process). Root cause identified as needing to ensure adequate staffing levels and a need for education for dietary staff on requirements for meal times. Food Services Director will communicate staffing levels for the kitchen to the Administrator at daily at Stand-up meeting and Stand-down meeting or by email, for the day of the communication and the day following the communication to ensure adequate staffing levels and/or implement a plan to reach adequate staffing levels. On Fridays, the schedule for the whole weekend and Monday will be reviewed by the Administrator and Food Services Director and the Food Services Director will communicate any changes to the Administrator as they occur so a plan can be made to reach required staffing levels. Food Services Director submits meal delivery logs to Administrator daily, and for the weekends on Monday. The Administrator and/or Director of Nursing are responsible for the corrective action. Food Services Director and Administrator will audit meal delivery times and kitchen staffing levels for breakfast, lunch and dinner daily for four weeks to ensure meal deliveries match facility meal schedule which matches the regulations for timing between meals. Weekend meal delivery times and staffing	10/06/2026

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F0809 SS = F	Continued from page 2 During an interview on 08/23/26 at 12:37 PM, Resident (R)185 stated breakfast was "extremely late" and further stated food service was "late a lot." Review of the electronic medical record (EMR) revealed R185 was cognitively able to communicate concerns regarding meal service delays. During an interview on 08/23/26 at 1:15 PM, CNA 4 confirmed lunch was late, and stated meal delays had occurred on other occasions, including breakfast service on 08/23/26. During an interview on 08/23/26 at 1:56 PM, CNA 6 stated trays normally arrived on her section of the Bethany unit between 12:30 PM and 12:45 PM but acknowledged meals had been "late a lot." Observation on 08/23/26 at 1:50 PM revealed facility staff delivered lunch trays to the Bethany unit. Residents on the Bethany unit received lunch more than one hour after the scheduled lunch service period of 11:50 AM to 12:50 PM had ended. During an interview on 08/25/26 at 10:19 AM, CNA 5 stated meals were late more often than not. CNA 5 reported delays affected all three meals, and stated trays had, at times, not arrived until approximately 2:30 PM, requiring nursing staff to remain beyond their scheduled shifts to assist residents with meals. During the Resident Council meeting on 08/25/26 at 11:04 AM, six of six residents stated mealtimes varied from day to day and reported they often did not know when meals would arrive. During an interview on 08/25/26 at 10:39 AM, R75 stated meal service had become increasingly delayed in recent months. Review of R75's quarterly "Minimum Data Set (MDS)" assessment with an Assessment Reference Date (ARD) of 06/25/26 in the EMR under the "MDS" tab revealed a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15, indicating R75 was cognitively intact and able to reliably report	F0809	Continued from page 2 levels will be reviewed on Mondays. As noted above, weekend staffing levels will be communicated throughout the weekend between the Food Services Director and Administrator to correct as needed. Audits will be conducted daily until four consecutive weeks of 100% compliance are achieved. Audits will then be conducted weekly for an additional two months. Results of these audits will be brought to the QAPI Committee for further review and recommendations. Date of Compliance: 10/6/2026	10/06/2026

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F0809 SS = F	Continued from page 3 concerns regarding meal service. During an interview on 08/26/26 at 9:13 AM, the Registered Dietitian (RD) acknowledged concerns regarding late meal service and stated the facility was actively attempting to improve the meal-delivery process. During an interview on 08/26/26 at 10:15 AM, the Administrator confirmed awareness that meals had been served late on multiple occasions and stated the facility was working to improve dietary operations following the hiring of a new Dietary Manager. Review of the facility's policy titled "Frequency of Meals," revised February 2022 indicated that the facility would establish meal service times and provide meals at regular times comparable to normal community mealtimes.	F0809		10/06/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by:	F0812	F0812 - Kitchen Sanitation Immediately upon discovery, identified areas and items were addressed and reviewed by dietary manager to ensure sanitation requirements were met. All residents have the potential to be affected. Upon discovery, identified areas and items were addressed and reviewed by dietary manager to ensure sanitation requirements were met. Food Services Director and Administrator began conducting daily rounds on identified areas to ensure the cleanliness standards were maintained. Staff Development Coordinator and Unit Managers will educate nursing staff on requirements for cleaning, labeling and dating, and ice scoop placement regarding the nourishment rooms on each unit. Education will include (but not be limited to) what needs to be kept clean, what needs to be labeled and dated, the process for labeling/dating and what date to use when dating, glove use and hand-hygiene. Reviewing the noted areas will be added to the Unit Managers' and Weekend Supervisors' daily rounds to be completed, logged and reviewed for deficient areas. Food Services Director will educate Dietary Staff on requirements for cleaning, labeling and dating, ice scoop	10/06/2026

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F0812 SS = F	Continued from page 4 Based on observation, interview, policy review, and review of the Food and Drug Administration (FDA) Food Code guidelines, the facility failed to ensure refrigerated and frozen food was properly labeled and dated, protected from contamination, and stored in a sanitary manner; failed to ensure kitchen equipment and residents' nutrition pantries were maintained in a sanitary condition; and failed to ensure dietary staff followed proper hand hygiene and glove-use practices during food preparation and tray-line service. This deficient practice had the potential to affect 163 of 165 residents who received meals and nourishment prepared in the facility kitchen. Findings include: Observation on 08/23/26 at 10:30 AM in the kitchen revealed the following: Inside the walk-in refrigerator, a tray containing a yellow-colored substance was stored without a label or date and was covered with plastic wrap. Also stored on a shelf was a tray of discolored, overripe, and waterlogged strawberries that was not labeled or dated. The plastic covering contained a large hole, leaving the product inadequately protected from contamination. Cook 1 confirmed at the time of the observation that the items were strawberries and pineapples and acknowledged they should have been labeled, dated, and properly secured. Cook 1 stated the items appeared to be beyond their use. Observation also revealed onion husks and other debris on the walk-in refrigerator floor. Observation of the walk-in freezer revealed excessive frost accumulation. The freezer lacked an internal thermometer for monitoring freezer temperatures. Observation of the reach-in freezer revealed an unlabeled, partially consumed bottle of Gatorade and a large unlabeled and undated clear bag containing frozen, yellow-colored food items. When questioned at the time of the observation, Cook 1 stated he believed the contents were eggs but could not identify why the product was stored or how long it had been present. Opened hot dogs, gravy, cooked ground chicken, chicken noodle soup, pork chops, and pasta were not labeled or dated. Cook 1 stated that the evening cook sometimes placed leftovers into storage and waited until the following day to label and date the food items.	F0812	Continued from page 4 placement and glove use. Education will include (but not be limited to) what needs to be kept clean, what needs to be labeled and dated, the process for labeling/dating and what date to use when dating, glove use and hand-hygiene. Root cause identified as a need for education and oversight of the identified areas. Reviewing the noted areas will be added to the Food Services Director's (or Supervisor's in his absence) daily rounds to be completed, logged and reviewed for deficient areas including monitoring glove use and hygiene during food preparation and noting any areas for improvement. The Administrator and/or Director of Nursing are responsible for the corrective action. Administrator will audit Unit Managers' and Weekend Supervisors' daily round sheets which will include reviews of nourishment rooms daily (Saturday and Sunday will be reviewed on Monday) to ensure all areas are clean, food is labeled, dated and unexpired, and ice scoop is properly placed. Administrator will audit Dietary Director and Supervisor's kitchen round sheets (which will include the above noted areas as well as glove use and hand hygiene during food preparation) daily (Saturday and Sunday will be reviewed on Monday) to ensure all areas are clean, food is labeled, dated and unexpired, ice scoop is properly placed, and required glove use and hygiene practices are being followed. Daily audits will continue for four weeks until four consecutive weeks of 100% compliance is achieved. Audits will then be conducted weekly for two months. Results of these audits will be brought to the QAPI Committee for further review and recommendations. Date of Compliance: 10/6/2026	10/06/2026

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F0812 SS = F	Continued from page 5 Observation of the kitchen ice machine revealed dark residue and pink-colored buildup on the interior surfaces and seams of the machine. During an interview on 08/24/26 at 11:39 AM, the Dietary Manager (DM) and Regional Dietary Manager (RDM) were informed of the food-labeling, storage, and sanitation concerns identified on 08/23/26. The DM stated all staff, particularly cooks, should properly store, label, and date foods before placing them into refrigeration. When shown the buildup within the ice machine, the DM stated maintenance staff were responsible for cleaning the ice machine. During the interview and observation of the ice machine, the DM removed an ice scoop that had been stored inside the ice machine and acknowledged it should not be stored in contact with the ice. The RDM stated the ice scoop should not have been stored in the ice bin. Review of the facility's policy titled "Ice," dated May 2014, indicated: "Ice will be prepared and distributed in a safe and sanitary manner ... Ice bins will be cleaned monthly ... Ice scoops will be cleaned and stored in a separate container that limits exposure to dust and moisture retention." Review of the facility's policy titled "Dietary Equipment," dated May 2014, indicated: "All food service equipment will be clean, sanitary, and in proper working order." During tray-line observation beginning on 08/24/26 at 12:12 PM, while preparing cheese quesadillas and wearing gloves, the DM touched food items and multiple food-contact and non-food-contact surfaces, including tortillas, cheese, bread, utensils, refrigerator doors, oven handles, temperature controls, steam-table components, pans, and containers, without changing gloves or performing hand hygiene. At 12:24 PM, the DM removed his gloves and did not perform hand hygiene. At 12:45 PM, the DM donned gloves without performing hand hygiene and resumed food preparation. At 12:54 PM, the DM changed gloves without performing hand hygiene. Review of the facility's policy titled "Food Preparation," dated May 2014, indicated staff were to practice proper handwashing techniques and glove	F0812		10/06/2026

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F0812 SS = F	Continued from page 6 use. Review of the facility's policy titled "Standard Precautions," dated May 2014, required staff to remove gloves promptly after use and perform hand hygiene upon glove removal. Observation on 08/26/26 at 11:46 AM in the Rehoboth Unit residents' nutrition pantry revealed the ice breaker within the ice machine was covered with a pink-colored substance, and water was observed dripping from the component directly onto the ice. Observation also revealed unlabeled beverages and partially consumed food items stored in the pantry, including a fruit-flavored beverage, a half-filled bottle of juice, a bottle of soda, a bottle of water, an open bag of candy, an unopened microwave meal, and an individual package of peanut butter cups. The interior surfaces and glass plate of the microwave contained food splatter. Observation on 08/26/26 at 11:51 AM in the Fenwick Unit residents' nutrition pantry revealed the interior surfaces and glass plate of the microwave contained food splatter. The pantry freezer did not seal properly because of excessive frost accumulation and contained an unlabeled microwave meal and an unlabeled carton of ice cream. Food debris and frozen-liquid residue were observed throughout the freezer compartment. Review of the facility's Food Preparation policy stated, "All foods are prepared in accordance with the FDA Food Code." Review of the U.S. FDA Food Code, available at https://www.fda.gov/food/retail-food-protection/fda-food-code, indicated food shall be protected from contamination during storage, preparation, and service; refrigerated ready-to-eat, time/temperature control for safety (TCS) foods shall be properly date marked; food-contact surfaces and equipment shall be maintained clean to sight and touch; food employees shall perform hand hygiene at appropriate times, including after glove removal; and gloves shall be changed as necessary to prevent contamination of food.	F0812		10/06/2026
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F0880	F0880 - Infection Control Cold Water temperatures	10/06/2026

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F0880 SS = F	Continued from page 7 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F0880	Continued from page 7 Upon discovery cold water temperatures for the building were tested and found to be within required temperature range. Tests included shower rooms, resident rooms, nourishment rooms and kitchen. All residents have the potential to be affected. Facility water temperatures were taken and Facility Maintenance Director was educated on the Facility Water Management Plan by the Regional Maintenance Director. Maintenance Director and Facility Management Team educated by Administrator and Regional Maintenance Director on Facility Water Management Plan including policy and procedure for testing cold water temperatures. Root cause determined to be a need for education on Facility Water Management Plan. The Facility Maintenance Director or Facility Maintenance Technician assigned will conduct Maintenance Infection Control Rounds, which includes a schedule for audits of hot and cold water temperatures, daily in perpetuity as part of required rounds. The Administrator and/or Director of Nursing are responsible for the corrective action. Administrator will audit Maintenance Infection Control Round sheets, which include cold and hot water temperature test log, weekly until four consecutive weeks of 100% compliance is achieved, at which point the audits will be conducted monthly for an additional two months. Results of these audits will be brought to the QAPI Committee for further review and recommendations. Tracking, Trending and Analyzing infections Facility is unable to correct the deficient practice as it occurred in the past. Residents experiencing infections have to be affected. A report was conducted of residents experiencing infections and the infections were tracked, trending and analyzed using the procedure laid out CDC National Healthcare Safety Network Long Term Care Facility Component Manual. Results of analysis were reviewed at Facility Weekly Risk Meeting with the IDT and Medical Director. Nurse Managers were educated by Regional Director	10/06/2026

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F0880 SS = F	Continued from page 8 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on document review, interviews, observations, and policy review, the facility failed to establish, implement, and maintain an effective infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed to: (1) monitor cold-water temperatures, establish control limits, and implement corrective-action thresholds as part of its water management program; (2) track, trend, analyze, and document corrective actions for infections identified through surveillance activities; and (3) ensure staff maintained medications and medication administration supplies in a sanitary manner. These deficient practices had the potential to affect all 165 residents residing in the facility and increased the risk for the development and transmission of infection. Findings include: 1. Review of facility-provided documentation titled "Air & Water Temperature Log" for the months of 06/2026 through 08/2026 revealed the facility failed to document and monitor cold-water temperatures. The documentation also lacked evidence that the facility established control limits, corrective-action thresholds, or monitored cold-water temperatures as part of its water management program. Review of the facility's Water Management Program	F0880	Continued from page 8 of Clinical Services on policy and procedure for tracking, trending, analyzing or documenting corrective actions related to identified infections. Root cause determined to be a need for education relating to Infection Control policy relating to tracking, trending, analyzing or documenting corrective actions related to identified infections. Infection review (including tracking, trending, analyzing and documenting corrective actions) will be added to the Weekly Risk Meeting with the IDT and Medical Director. The Administrator and/or Director of Nursing are responsible for the corrective action. Facility DON will conduct a weekly audit of identified infections to ensure policy and procedure is followed for tracking, trending, analyzing or documenting corrective actions. Audit will be conducted weekly until four consecutive weeks of 100% compliance is achieved, at which point the audits will be conducted monthly for an additional two months. Results of these audits will be brought to the QAPI Committee for further review and recommendations. Injector Pen Infection Control Facility is unable to correct the deficient practice relating to R139 as this event occurred in the past. Other residents with orders for injector pens have the potential to be affected. A report was conducted of other residents with orders for injector pens and the residents were reviewed by the Director of Nursing to ensure no negative outcomes from potential mishandling of the injector pens (such as signs or symptoms of infection). All residents were deemed unaffected. Licensed Nurses will be trained by Staff Development Coordinator, DON or ADON on ensuring a barrier is in place before setting down injector pens. Root cause determined to need for education. Facility will purchase trays/baskets to act as barriers for this use and educate licensed nurses on their use (including cleaning between use). The Administrator and/or Director of Nursing are responsible for the corrective action. Unit Managers will conduct daily audits of licensed nurses using injector pens to ensure a barrier is in	10/06/2026

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 08/26/2026

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PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD , WILMINGTON, Delaware, 19808**

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F0880 SS = F	Continued from page 9 revealed the facility failed to establish cold-water monitoring parameters, control limits, and corrective-action thresholds for cold-water temperatures. During an interview on 08/25/26 at 2:40 PM, the Maintenance Director stated he had never monitored cold-water temperatures and only monitored hot-water temperatures. During an interview on 08/26/26 at 9:52 AM, the Regional Director of Clinical Services (RDCS) stated she was aware that staff should monitor cold-water temperatures as part of an effective water management program. During an interview on 08/26/26 at 10:51 AM, the Assistant Director of Nursing (ADON)/Infection Preventionist (IP), stated that she was unaware that staff needed to monitor cold-water temperatures as part of the facility's water management program. Review of the CDC webpage titled "Water Management Program to Reduce Legionella Growth and Spread in Buildings," dated 03/15/24, indicated, ". . . Seven steps of a Legionella water management program (WMP) are to: Establish a WMP team . . . Describe the building water systems . . . Identify areas where Legionella could grow and spread . . . Decide where to apply and how to monitor control measures . . . Establish interventions when control limits aren't met . . . Ensure the program runs as designed and is effective . . . Document and communicate all the activities . . ." Review of a CDC document titled "Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings," dated 06/24/21, indicated, ". . . Water temperature fluctuations provide conditions where Legionella grows best (77°F-113°F); Legionella can still grow outside this range . . . In hot weather, cold water in pipes can heat up into this range . . ." By failing to monitor cold-water temperatures and establish control measures, the facility increased the potential risk for Legionella growth and spread within its water system and increased the risk of exposure to waterborne pathogens for residents, staff, and visitors.	F0880	Continued from page 9 place before setting injector pens down. Audit will be conducted daily until four consecutive weeks of 100% compliance is achieved, at which point the audits will be conducted weekly for an additional two months. Results of these audits will be brought to the QAPI Committee for further review and recommendations. Employee personal items on Medication Carts Upon discovery, staff personal items and food were removed from medication cart. All residents receiving medications from medication carts have the potential to be affected. Director of Nursing and Assistant Director of Nursing rounded the Center and any staff personal items and/or food noted on medication carts were removed from medication carts on all units. Licensed nurses will be educated by Staff Development Coordinator that personal items including food and drinks are not permitted on medication carts. Root cause determined to be a need for education and oversight. The Administrator and/or Director of Nursing are responsible for the corrective action. Signs will be permanently adhered to medication carts stating no food, drink or personal items are to be placed on medication carts. The Administrator and/or Director of Nursing are responsible for the corrective action. Unit Managers will conduct daily audits of medication carts to ensure carts are free from staff personal items and food. Manager on Duty will complete audits on weekends. Daily audits will continue until four weeks of 100% compliance is achieved. Once achieved, audits will be conducted weekly for two additional months. Results of audits will be brought to the QAPI Committee for further review and recommendations. Date of Compliance: 10/6/2026	10/06/2026

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F0880 SS = F	Continued from page 10 2. Review of documents provided by the facility titled "Infection Control Report" for the months of 01/2026 through 08/2026 revealed the facility did not track, trend, analyze, or document corrective actions related to identified infections. The facility failed to document resident-specific surveillance data, analyses, trending information, and corrective actions necessary to identify infection patterns, clusters, outbreaks, and opportunities for performance improvement. For each month, the reports contained headings including fungal infections, skin infections, leukocytosis, urinary tract infections, respiratory infections, wound infections, and eye infections. Under each heading, staff documented only the total number of infections. Staff did not document resident names, investigation dates, antibiotic use, or whether the infections met criteria for antibiotic treatment. During an interview on 08/26/26 at 10:51 AM, the ADON/IP stated the clinical management team met each morning and reviewed the electronic medical record (EMR) dashboard for new antibiotic orders. The IP stated staff had prepared the monthly summaries in this format for several years. The IP further stated staff did not perform tracking or trending beyond discussions conducted during daily clinical management meetings and relied on those discussions to identify potential clusters or outbreaks. The IP stated this was how she was trained to collect infection control information. Review of the facility's policy titled "Collection Methods and Monitoring," dated 11/17/20, indicated, ". . . Determine what information is essential for effective analysis. Essential information for routine surveillance includes . . . Patient name . . . Room number . . . Location in Center . . . Attending physician . . . Site of infection . . . Agent of infection (bacteria, virus, fungus, etc.) and antibiotic sensitivities . . . Date of admission and onset of infection . . . Additional categories can be added as needed for individual cases . . . Antibiotic report and antibiogram report . . . Compiling surveillance information on a line listing is one of the quickest methods of organizing the data for analysis . . . Line listings should be reviewed at least weekly by the Infection Preventionist or designee . . . The data should be analyzed by nursing units, anatomic sites,	F0880		10/06/2026

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F0880 SS = F	Continued from page 11 and/or organisms with similar antibiotic sensitivities. The analysis may identify infection problems and suggest common-source infections or cross-infections . . ." Review of the CDC National Healthcare Safety Network (NHSN) Long-Term Care Facility Component Manual dated 01/2026 indicated, ". . . Surveillance is defined as the ongoing systematic collection, analysis, interpretation, and dissemination of data. A facility infection prevention and control program should use surveillance to identify infections and monitor performance of practices to reduce infection risks among residents, staff, and visitors . . . Data collection requires active, resident-based, prospective surveillance . . ." By failing to track, trend, analyze, and document corrective actions related to infections, the facility limited its ability to identify infection trends, detect potential outbreaks, implement timely interventions, and evaluate the effectiveness of infection prevention and control practices. 3. Review of Resident (R) 139's Face Sheet, located under the Profile tab in the electronic medical record (EMR), revealed R139 was admitted to the facility on 05/20/26 with a diagnosis of diabetes mellitus. Review of R139's quarterly "Minimum Data Set (MDS)" located under the "MDS" tab in the EMR, with an Assessment Reference Date (ARD) of 08/07/26, revealed a "Brief Interview for Mental Status (BIMS)" score of 10 out of 15, indicating moderate cognitive impairment. Review of R139's "Physician Orders" located under the "Orders" tab in the EMR, revealed an active order dated 07/13/26 for Insulin Glargine Subcutaneous Solution Pen Injector 100 units/ml, inject 12 units subcutaneously once daily for diabetes mellitus. During an observation of medication administration on 08/25/26 at 9:05 AM, Licensed Practical Nurse (LPN)5 entered R139's room to administer the ordered insulin pen. LPN5 placed the pen injector directly on R139's bedside table without first cleaning the surface or placing a protective barrier between the pen injector and the bedside table.	F0880		10/06/2026

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F0880 SS = F	Continued from page 12 LPN5 applied gloves, retrieved the pen injector from the bedside table, and administered the insulin subcutaneously to R139. Following administration, LPN5 placed the pen injector directly back onto the bedside table, removed her gloves, performed hand hygiene, retrieved the pen injector from the bedside table, and returned it to the medication cart. LPN5 placed the pen injector directly on the bedside table without the barrier required by facility policy and then returned the pen injector to the medication cart after environmental surface contact, creating the potential for contamination. During an interview on 08/25/26 at 9:13 AM, LPN5 stated she was unaware that a barrier was required when placing a pen injector on a surface in a resident's room. During an interview on 08/26/26 at 10:45 AM, the ADON/IP verified that a barrier was required when medications or injection supplies were placed on a resident's bedside table. During an interview on 08/26/26 at 11:00 AM, the RDCS verified that a barrier was required when medications or supplies were placed on surfaces within a resident's room. Review of the facility's policy titled "Administration Procedures for All Medications," revised 08/2020, revealed staff were directed to use a barrier, such as a clean disposable tray or plastic cup, when carrying medication containers into a resident's room and to separate medication supplies from the overbed table or other surfaces where medications were administered. By failing to use the required barrier during medication administration, staff increased the potential for contamination of the medication delivery device and increased the risk of infection associated with unsafe medication administration practices. 4. During an observation of the medication cart on 08/25/26 at 9:20 AM, a donut resting on a paper napkin was observed in the top drawer of the medication cart among resident medications. Two	F0880		10/06/2026

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F0880 SS = F	Continued from page 13 capped thermoses containing coffee and water were observed in another drawer of the medication cart resting directly on top of medication pill packs. During an interview on 08/25/26 at 9:22 AM, LPN5 identified the donut, coffee, and water as her personal food and beverages. LPN5 stated she kept the beverages in the medication cart because she became dehydrated during medication administration. LPN5 verified personal food and beverages were not permitted to be stored in the medication cart and stated the items should have been kept in the staff break room. During an interview on 08/26/26 at 10:45 AM, the ADON/IP verified that staff food and beverages were not permitted to be stored in medication carts with resident medications. During an interview on 08/26/26 at 11:00 AM, the RDCS verified that staff food and beverages were not permitted to be stored in medication carts with resident medications. By storing personal food and beverages in the medication cart with resident medications, staff increased the potential for contamination of medication supplies and resident medications and failed to follow accepted infection prevention and medication storage practices.	F0880		10/06/2026
F0552 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.	F0552	F0552 - Consents and behavior monitoring for psychotropic medications Upon discovery, consent for the medication for R-187 was obtained. Residents with orders for psychotropic medications have the potential to be affected. Facility DON ran a report of residents with orders for psychotropic medications and verified an informed consent was present for each. Licensed Nurses will be educated by the Staff Development Coordinator, ADON or DON on obtaining informed consents for residents with new orders for psychotropic medications. Root cause assessed to be a need for staff education on informed consent process. New psychotropic orders	10/06/2026

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F0552 SS = D	Continued from page 14 §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 record review, interviews, and policy review, the facility failed to obtain and document informed consent prior to administering a psychotropic medication for one (Resident (R) 187) of five residents reviewed for unnecessary medications. The facility's failure to obtain and document informed consent before administering lorazepam deprived the resident and/or resident representative of the opportunity to participate in treatment decisions and receive information regarding the medication's risks, benefits, alternatives, expected outcomes, and right to refuse treatment. Findings include: Review of R187's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), indicated the resident was admitted to the facility on 08/11/26 with a diagnosis of adult failure to thrive. Review of R187's admission "Minimum Data Set (MDS)", located under the "MDS" tab, with an Assessment Reference Date (ARD) of 08/17/26 and a "Brief Interview for Mental Status (BIMS)" score of eight out of 15, revealed the resident was moderately cognitively impaired. Review of R187's EMR revealed the facility did not document informed consent for lorazepam from either the resident or the resident representative. Review of R187's "Physician Orders," located under the "Orders" tab of the EMR, dated 08/20/26, revealed an order for lorazepam (psychotropic) oral tablet 0.5 milligrams (mg) to be administered every four hours as needed for 14 days. Review of R187's "Medication Administration Record (MAR)", located in the EMR under the "Orders" tab for August 2026, revealed facility staff administered lorazepam on 08/22/26 at 12:38 AM and 6:50 PM, 08/23/26 at 5:54 PM and 10:22 PM, and 08/24/26 at	F0552	Continued from page 14 will be added to the Weekly Risk Meeting agenda with the IDT and the Medical Director to ensure an informed consent is present for each. The Administrator and/or Director of Nursing are responsible for the corrective action. Facility DON and ADON will conduct a weekly audit of residents with new orders for psychotropic medications to ensure the informed consent is completed. Once four consecutive weeks of audits demonstrate 100% compliance, the audits will be conducted monthly for an additional two months. Results of these audits will be brought to QAPI Committee for further review and recommendations. Date of Compliance: 10/6/2026	10/06/2026

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F0552 SS = D	Continued from page 15 12:21 PM. Review of R187's EMR, including available consent records, physician orders, and clinical documentation, revealed the facility did not complete a psychotropic medication informed consent prior to administering lorazepam. Further review revealed the facility did not document that it informed the resident or resident representative of the medication's risks, benefits, alternatives, expected outcomes, or right to refuse treatment before administering the medication. During an interview on 08/24/26 at 1:51 PM, the Director of Nursing (DON) confirmed the facility had not completed informed consent for lorazepam before staff administered the medication. The DON further confirmed the facility had no evidence that staff educated the resident or resident representative regarding the medication's risks, benefits, alternatives, expected outcomes, or right to refuse treatment. The DON stated she began completing the informed consent form on or about the previous Thursday but did not complete it until 08/24/26. The DON stated the charge nurse would typically complete the psychotropic medication informed consent. Review of the facility's policy titled "Chemical Restraints," dated 07/18/25, indicated, ". . . Document informed consent for psychotropic medication administration using the Informed Consent for Psychotropic Medication Assessment. . ." As of 08/24/26, the facility administered lorazepam to R187 on five occasions without obtaining and documenting informed consent from the resident or resident representative and without documenting that it provided information regarding the medication's risks, benefits, alternatives, expected outcomes, and right to refuse treatment before administration.	F0552		10/06/2026
F0600 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	F0600	"Past Noncompliance - no plan of correction required"	09/10/2026

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F0600 SS = D	Continued from page 16 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 interviews, record review, and policy review, the facility failed to protect one of seven residents (Resident (R) 36) reviewed for physical abuse by another resident (R21) among 42 sampled residents. This failure had the potential to result in physical and/or psychosocial harm. Findings include: The deficient practice was determined to be past noncompliance related to the facility identifying the resident-to-resident abuse and implementing interventions to prevent reoccurrence of the situation, completed on 06/17/26. The facility's actions included the following: The aggressive resident (R21) involved in the 06/09/26 resident-to-resident abuse incident was removed from the situation and placed on one-to-one (1:1) supervision. R21 was transferred to the Emergency Room for evaluation. R21 was cleared to return to the facility, and 1:1 supervision resumed The aggressive resident (R21) was moved to the second floor away from (R36), who was on the first floor The police department was notified, and the situation was investigated. Family of both residents notified of incident and Medical Doctor notified Psychiatric Evaluation completed 06/17/26 for both	F0600		09/10/2026

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F0600 SS = D	Continued from page 17 R21 and R36 Staff were in-serviced on abuse prevention Care plan was revised with interventions No other abuse incidents involving R21 and other residents since the 06/09/26 incident Findings include: Review of R36's "Admission Record" located under the "Profile" tab in the electronic medical record (EMR) revealed R36 was admitted to the facility on 03/16/23 with diagnoses including unspecified dementia, major depressive disorder, and cognitive communication deficit. Review of R36's quarterly "Minimum Data Set (MDS)" located under the "MDS" tab in the EMR with an Assessment Reference Date (ARD) of 06/05/26 revealed a "Brief Interview for Mental Status (BIMS)" score of five out of 15, indicating severe cognitive impairment. Review of R36's "Care Plan," revised on 06/16/26, revealed R36 had signs and symptoms of depression and was at risk of adverse reactions related to a recent negative interaction with a male resident. Review of R21's "Admission Record" located under the "Profile" tab in the electronic medical record (EMR) revealed R21 was admitted to the facility on 05/25/23 with diagnoses including alcohol dependence with alcohol-induced persisting dementia, cognitive communication deficit, dementia, anxiety disorder, and alcohol abuse with other alcohol-induced disorder. Review of R21's quarterly "Minimum Data Set (MDS)" located under the "MDS" tab in the EMR with an Assessment Reference Date (ARD) of 08/13/26 revealed a "Brief Interview for Mental Status (BIMS)" score of 99, indicating R21 was unable to complete the interview. A Staff Assessment for Mental Status (SAMS) indicated R21 had long- and short-term memory problems. Review of R21's "Care Plan Report," revised on 06/10/26, revealed R21 exhibited behaviors including use of profanity, refusing showers and treatments, being verbally aggressive toward staff and residents,	F0600		09/10/2026

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F0600 SS = D	Continued from page 18 pacing the hallway, wandering into other residents' rooms, and being physically aggressive toward other residents and staff. The "Care Plan" indicated an intervention initiated on 01/19/26 directing staff to ensure familiar staff members worked with R21. An intervention initiated on 02/23/25 directed staff to provide R21 with diversional activities and take him to a quiet area if he became overstimulated. Review of "Incident Tracking," dated 06/09/26, revealed R21 entered R36's room and hit R36 on the forehead. R36 then lifted her arm to shield her face, and R21 grabbed her arm, causing a scratch. Staff immediately redirected R21 out of the room and placed him on 1:1 staff supervision. Review of Licensed Practical Nurse (LPN) 11's written statement, dated 06/09/26, revealed she was in the hallway and heard yelling coming from R36's room. LPN11 documented that R36 reported R21 had attacked her. R36 showed LPN11 a scratch on her left forearm caused by R21. Review of Certified Nurse Aide (CNA) 9's undated written statement revealed she heard yelling coming from R36's room. R36 and R174, R36's roommate, were yelling, "hey, stop get out (sic)!!" CNA9 entered the room and saw R21 standing in front of R36. R21 then turned and walked out of the room. R36 stated R21 was "swinging" at her and hit her. Review of LPN10's written statement, dated 06/09/26, revealed LPN11 informed him that R21 had "punched" another resident. LPN10 spoke with R36, who reported that R21 had punched her in the face and scratched her forearm. LPN10 observed a scratch on R36's arm. During a telephone interview on 08/25/26 at 6:15 PM, LPN11 stated she heard yelling coming from R36's room. As LPN11 entered the room, CNA9 was escorting R21 out of the room. R36 told LPN11 that R21 had hit her on the head and scratched her arm. LPN11 stated she immediately notified LPN10. During a telephone interview on 08/25/26 at 6:36 PM, LPN10 stated LPN11 notified him of the incident. He stated he spoke with R36, who reported that R21 had entered her room, hit her on the head, and scratched her arm. During an interview on 08/26/26 at 12:12 PM, the Assistant Director of Nursing (ADON) stated R21 hit R36. She stated R21 had not previously displayed aggression toward other residents; however, following the incident, he was placed on 1:1 staff	F0600		09/10/2026

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F0600 SS = D	Continued from page 19 supervision. During an interview on 08/26/26 at 1:26 PM, the Administrator stated R21 hit R36. He stated R21 had not previously had incidents involving other residents. The Administrator further stated that following the incident, R21 was placed on 1:1 staff supervision. The facility's records identified R21 as exhibiting verbal aggression toward residents, wandering into other residents' rooms, and being physically aggressive toward other residents and staff. Despite these identified behaviors, R21 entered R36's room and physically struck her, resulting in a scratch to her forearm. Review of the facility's policy titled "Abuse/Neglect/Misappropriation/Crime," dated 10/17/23, specified, "There is zero tolerance for mistreatment, abuse, neglect, misappropriation of property, or any crime against a patient of the Health and Rehabilitation Center... And all suspected or witnessed incidents of patient/patient abuse... or any reasonable suspicion of a crime against a patient... brought to the attention of the Center's Administration will result in internal investigation, appropriate and timely reporting to the State Survey agency... Patients are provided with a description of their legal rights, which include: The right to be free from... physical abuse..."	F0600		09/10/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of	F0605	F0605 - Behavior Monitoring Upon discovery, behavior monitoring for R-187 was initiated. Residents with orders for psychotropic medications have the potential to be affected. Facility DON ran a report of residents with orders for psychotropic medications and verified behavior monitoring was in place and consistently completed for each. Licensed Nurses will be educated by the Staff Development Coordinator, ADON or DON on conducting and documenting behavior monitoring for residents with orders for psychotropic medications. Residents with Psychotropic medication orders will be added to the agenda for the Weekly Risk Meeting with the IDT and Medical Director to ensure behavior monitoring is present for each. Root cause assessed to be need for education that behavior monitoring is still required for residents with orders for	10/06/2026

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F0605 SS = D	Continued from page 20 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)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in	F0605	Continued from page 20 psychotropic medications who are also receiving hospice services. The Administrator and/or Director of Nursing are responsible for the corrective action. Facility DON and ADON will conduct a weekly audit of residents with orders for psychotropic medications to ensure behavior monitoring is completed and documented. Once four consecutive weeks of audits demonstrate 100% compliance, the audits will be conducted monthly for an additional two months. Results of these audits will be brought to QAPI Committee for further review and recommendations. Date of Compliance: 10/6/2026	10/06/2026

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F0605 SS = D	Continued from page 21 paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy review, the facility failed to appropriately monitor one of five sampled residents (R187) receiving psychotropic medication. Specifically, the facility failed to document the target behaviors associated with the administration of as needed (PRN) psychotropic medication (lorazepam) and failed to monitor and document potential adverse side effects following administration. This failure had the potential to result in unrecognized adverse	F0605		10/06/2026

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F0605 SS = D	Continued from page 22 medication effects and ineffective evaluation of the need for and effectiveness of the medication. Findings include: Review of R187's "Admission Record" located under the "Profile" tab of the electronic medical record (EMR) indicated the facility admitted the resident on 08/11/26 with a diagnosis of adult failure to thrive. Review of R187's "Care Plan" located under the "Care Plan" tab of the EMR dated 08/12/26 indicated the resident was on psychoactive medications and was at risk for complications. The "Care Plan" directed staff to monitor behaviors related to medication use and observe for and document possible side effects. Review of R187's admission "Minimum Data Set (MDS)" located under the "MDS" tab dated 08/17/26 revealed a "Brief Interview for Mental Status (BIMS)" score of eight out of 15, indicating the resident was moderately cognitively impaired. Review of R187's "Physician Orders" located under the "Orders" tab of the EMR dated 08/20/26 revealed an order for lorazepam (psychotropic) oral tablet 0.5 milligrams (mg) to be administered every four hours PRN for 14 days for anxiety. Review of R187's "Medication Administration Record (MAR)," located in the EMR under the "Orders" tab for August 2026, included instructions directing clinical staff to monitor behaviors each shift. From 08/20/26 through the day shift on 08/24/26, staff documented no behaviors. On the evening shift of 08/20/26, staff documented one behavior indicating the resident experienced a mood swing. Staff documented no behaviors on the night shift. Review of the "MAR", nursing progress notes, and other clinical documentation from 08/20/26 through 08/24/26 revealed no evidence that staff documented target behaviors supporting the administration of lorazepam or monitored and documented potential adverse effects following administration. The "MAR" revealed staff administered lorazepam	F0605		10/06/2026

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F0605 SS = D	Continued from page 23 five times without documenting a specific target behavior or symptom to support the administration of the medication on the following dates and times: 08/22/26 at 12:38 AM and 6:50 PM; 08/23/26 at 5:54 PM and 10:22 PM; and 08/24/26 at 12:21 PM. Additionally, the "MAR" contained no evidence that staff monitored or documented potential adverse effects following the administration of lorazepam. During an interview on 08/24/26 at 1:51 PM, the Director of Nursing (DON) stated R187 was a hospice patient, and the goal was to make her as comfortable as possible. The DON stated she was unaware that staff were still required to monitor and document behaviors and potential adverse effects associated with psychotropic medications administered to residents receiving hospice services. Review of the facility's policy titled "Chemical Restraints," dated 07/18/25, indicated, ". . . Patients receiving any psychoactive medications, regardless of the reason for use, will be monitored for the occurrence of specific behavioral symptoms and adverse side effects by a licensed nurse..."	F0605		10/06/2026
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, 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	F0609	F0609 - Timely reporting (one self report five day was late) Facility is unable to retroactively correct this incident as it occurred in the past. The Five-day report was submitted. Residents for whom facility needs to Report incidents to the State have the potential to be affected. Administrator ran a report of residents for the past thirty days prior to Survey Entrance (8/23/26) to ensure all five-day reports were submitted timely and all were found to be in compliance. Administrator educated nurse managers on timely reporting requirements for Facility Reported Incidents and how to ensure the Reports are completed in the State Portal. The due date for new Facility Reported Incidents and verification existing Facility Reported Incidents were submitted on time will be added to the Agenda for the Weekly Risk Meeting with the IDT and Medical Director. Facility Reported Incidents (including five-day report due dates and verification of timely reporting) will also be added to the Daily Stand-up Meeting Agenda.	10/06/2026

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F0609 SS = D	Continued from page 24 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, interview, and policy review, the facility failed to ensure the results of an investigation involving an allegation of physical abuse were reported to the State Agency (SA) within five working days for one (Resident (R) 29) of seven abuse investigations reviewed from a sample of 42 residents. This deficient practice had the potential to delay SA oversight and intervention, which could affect the timely identification and correction of conditions that may place residents at risk for abuse. Findings include: Review of R29's electronic medical record (EMR) revealed the resident was originally admitted on 06/19/26 with a diagnosis of dementia. The EMR contained an admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 06/25/26 and a "Brief Interview for Mental Status (BIMS)" score of 11 out of 15, indicating moderate cognitive impairment. Review of the facility's abuse investigation documentation revealed that R29 alleged staff-to-resident physical abuse. Documentation indicated that the Director of Nursing (DON)/Administrator notified the SA of the allegation on 07/30/26. The facility's investigation concluded that the allegation could not be substantiated. However, the investigation file contained no evidence that the facility submitted the required final five-working-day report to the SA. During an interview on 08/26/26 at 12:28 PM, the Administrator confirmed the facility did not report its investigation findings to the SA within the required five-working-day timeframe. The Administrator stated staff had overlooked the reporting requirement. Review of the facility's policy titled "Abuse," dated 02/05/23, indicated, "The Administrator must thoroughly investigate and file a complete written	F0609	Continued from page 24 Root cause determined to be education needed on use of the State Portal's system for drafts and complete reports. The Administrator and/or Director of Nursing are responsible for the corrective action. Administrator will conduct a weekly audit of facility reported incidents to ensure all five-day reports are completed and submitted timely. Once four consecutive weeks of audits demonstrate 100% compliance, the audits will be conducted monthly for an additional two months. Results of these audits will be brought to QAPI for further review and recommendations. Date of Compliance: 10/6/2026	10/06/2026

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F0609 SS = D	Continued from page 25 report of the investigation of the submitted FRI to the State Agency within five (5) working days of the incident."	F0609		10/06/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interviews, policy review, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure the accuracy of a Minimum Data Set (MDS) assessment for one of five residents (Resident (R) 9) reviewed for PASRR status out of 42 sampled residents. The facility inaccurately coded R9's PASRR Level II	F0641	F0641 - Assessments – MDS and PASSR Immediately upon discovery the MDS for R9 was updated to include Level II PASRR. All residents have the potential to be affected. An audit of all in-house residents was conducted by the Social Services Director to ensure all residents with Level II PASRR's were identified. MDS Director audited MDSs for all residents identified to ensure the Level II PASRRs were included in the MDS. Any resident MDS's missing Level II PASRRs were corrected and modifications were submitted. Regional MDS Director and Regional Social Services Director educated Social Services Staff and MDS Staff that the Social Services Department is responsible for the MDS Sections A1500, A1510 and A1550 which include the Level II PASRRs and on the process to identify Level II PASRRs at the time of admission and at least quarterly at time of care plan. Level II PASRRs will be added to the Daily Standup Meeting agenda when Quarterly Care Plans are reviewed to ensure discussion and review occurs of residents who require their MDS's to be updated with Level II PASRRs. Root cause assessed to be the need for education on process for identifying PASRRs and policy for completing the MDS. The Administrator and/or Director of Nursing are responsible for the corrective action. MDS Director will audit new residents admitted to the facility with Level II PASRRs to ensure the Level II PASRR is included in the MDS. Audits will be conducted weekly for four weeks until four consecutive weeks of audits demonstrate 100% compliance, at which time the audits will be conducted monthly for an additional two months. Results of these audits will be brought to QAPI for further review and recommendations. Date of Compliance: 10/6/2026	10/06/2026

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F0641 SS = D	Continued from page 26 status as "No" despite documentation indicating the resident met the criteria for a PASRR Level II evaluation and determination. Failure to ensure the accuracy of MDS assessments resulted in an inaccurate representation of the resident's PASRR Level II status in the federally required assessment. Findings include: Review of R9's "Admission Record" located under the "Profile" tab of the electronic medical record (EMR) indicated the resident was initially admitted to the facility on 09/20/23 and readmitted on 02/11/26 with diagnoses including schizoaffective disorder, bipolar type, bipolar disorder, obsessive-compulsive disorder, generalized anxiety disorder, and major depressive disorder. Review of R9's "Notice of PASRR Level II Outcome" located under the "Misc" tab of the EMR, dated 01/20/26, revealed R9 had diagnoses of schizoaffective disorder, bipolar type versus bipolar disorder with psychotic features, generalized anxiety disorder, major depressive disorder, and compulsive disorder and met the criteria for a PASRR Level II evaluation and determination. Review of R9's significant change MDS located under the "MDS" tab with an Assessment Reference Date (ARD) of 01/29/26 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating R9 was cognitively intact. The significant change MDS coded the item, "Is the resident currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?" as "No." The PASRR Level II determination was completed on 01/20/26 and uploaded into the EMR on 01/21/26, eight days prior to the ARD of the significant change MDS dated 01/29/26. Therefore, the interdisciplinary team had documentation supporting a PASRR Level II determination available when it completed the MDS assessment. During an interview on 08/26/26 at 9:39 AM, the MDS Coordinator (MDSC) reviewed R9's EMR and stated, "[R9] had a PASRR Level II dated 01/20/26 which was uploaded into the EMR on 01/21/26. The result of the Level II PASRR determination was qualifying serious mental illness (SMI)." The MDSC	F0641		10/06/2026

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F0641 SS = D	Continued from page 27 reviewed R9's significant change MDS dated 01/29/26 and confirmed it was coded "No" for PASRR Level II status. The MDSC stated, "It should have been marked Yes. I completed Section A." During an interview on 08/26/26 at 11:45 AM, the Assistant Director of Nursing (ADON) stated, "I would expect staff to accurately code the resident's PASRR Level II status on the MDS." Review of the facility's policy titled, "MDS Assessments," dated 01/23/20, indicated, "The Administrator ensures that the designated Health and Rehabilitation Center staff timely and efficiently completes and submits all scheduled MDS's." Although the facility policy addressed timely completion and submission of MDS assessments, staff failed to accurately code R9's PASRR Level II status on the significant change MDS. Review of the RAI 3.0 User's Manual dated 10/25 revealed, ". . . It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy [what the resident's actual status was during that observation period] by the IDT [Interdisciplinary Team] completing the assessment . . ." The facility failed to ensure the significant change MDS accurately reflected R9's PASRR Level II determination. Documentation supporting the PASRR Level II determination was available in the EMR before completion of the assessment, and the MDS Coordinator confirmed the item had been coded incorrectly.	F0641		10/06/2026
F0657 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	F0657	F0657 - Care Plan Revision Immediately upon discovery, Care Plan for R9 was updated by Social Worker to include the most recent Level II PASRR including new interventions based on Level II PASRR. All residents have the potential to be affected. An audit of all in-house residents was completed by the Social Services Department to ensure the most	10/06/2026

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(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
F0657 SS = D	Continued from page 28 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 record review, interviews, and policy review, the facility failed to update the comprehensive care plan to reflect revised PASRR Level II recommendations for one (Resident (R) 9) of 42 sampled residents reviewed for care planning. This failure resulted in R9's care plan not accurately reflecting the services and supports identified in the updated PASRR Level II evaluation dated 01/20/26 and had the potential to affect communication of the resident's current care needs among staff responsible for providing care and services. Findings include: Review of R9's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), indicated the resident was initially admitted to the facility on 09/20/23 and readmitted on 02/11/26 with diagnoses of schizoaffective disorder, bipolar type; bipolar disorder; obsessive-compulsive disorder; generalized anxiety disorder; and major depressive disorder. Review of R9's significant change Minimum Data Set (MDS) assessment, located under the "MDS" tab of the EMR with an Assessment Reference Date (ARD)	F0657	Continued from page 28 recent Level II PASRR for each resident is included in each resident's care plan. Any care plans requiring updates were corrected. Regional Director of Social Services educated Social Services Department on process and requirements for including the most recent Level II PASRRs in the care plan for each resident. At admission and at each quarterly care plan review, Social Services Director will review each resident's case to see if a new Level II PASRRs has been updated. Social Services Staff will document in each Resident Care Plan upon admission, quarterly, and as needed every time a resident's Care Plan is updated due to an update to the Level II PASRR or if no new Level II PASRR updates are required. Root cause determined to be lack of process for regularly checking for updates to residents' Level II PASRRs. The Administrator and/or Director of Nursing are responsible for the corrective action. Social Services Director will conduct a weekly audit of Resident Care Plans completed each week for newly admitted residents and residents receiving quarterly Care Plans to ensure the most recent Level II PASRRs were included in the care plan. Audits will include verification of a Level II PASRR and that the Care Plan was updated according to the PASRR with HIPAA compliant language addressing what the update included based on the PASRR. Audits will be conducted weekly for four weeks until four consecutive weeks of audits demonstrate 100% compliance, at which time the audits will be conducted monthly for an additional two months. Results of these audits will be brought to QAPI for further review and recommendations. Date of Compliance: 10/6/2026	10/06/2026

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 08/26/2026

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

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F0657 SS = D	Continued from page 29 of 01/29/26, revealed R9 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating the resident was cognitively intact. Review of R9's "Notice of PASRR Level II Outcome," located under the "Misc" tab of the EMR and dated 01/20/26, revealed the PASRR specified, ". . . Rehabilitation services: You will need to be provided the following services and/or supports: Occupational Therapy Evaluation, Physical Therapy Evaluation, Socialization/Leisure/Recreational Activities, family involvement or training in the individual's care, individual counseling, obtain archived psychiatric records to clarify history, ongoing evaluation of the effectiveness of current psychotropic medications on target symptoms, and support and encouragement by nursing facility staff." Review of R9's "Care Plan" located under the "Care Plan" tab of the EMR and dated 06/25/24, indicated the resident had a Level II PASRR dated 03/20/24 with the intervention, "Specialized services of Psychiatric Provider evaluation within 30 days of admission." The care plan goal specified, "One-time psychiatric medication management evaluation by psychiatrist/psychiatric nurse and the resident will exhibit fewer episodes of adverse behavior through review date." The care plan approaches included, "Administer medications as ordered. Monitor/document for side effects. Document goal and delivery of service in POC (Plan of Care). Evaluate response to psychotropic medications on target symptoms," dated 03/23/24; "Post-hospital psychiatric evaluation to be delivered within 30 days," dated 04/23/24; "Evaluation done on 04/17/24;" and "Psychological/Psychiatric interventions/consultation as ordered," dated 06/25/24. During an interview on 08/26/26 at 10:04 AM, the Social Services Director (SSD) stated, "I am responsible for updating care plans related to PASRR Level II recommendations." When asked if she was aware R9 had an updated PASRR, the SSD stated, "Yes. The most recent PASRR Level II was dated 01/20/26." The SSD reviewed R9's care plan and confirmed the care plan addressing the resident's PASRR Level II recommendations was dated 06/25/24 and corresponded to the PASRR Level II dated 03/20/24. When asked whether the care plan should have been updated to reflect the revised PASRR recommendations, the SSD stated,	F0657		10/06/2026

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F0657 SS = D	Continued from page 30 "There are some things that could probably be added." During an interview on 08/26/26 at 11:45 AM, the Assistant Director of Nursing (ADON) stated, "SSD would be responsible for updating the care plan regarding PASRR Level II evaluations." Review of the facility's policy titled, "Level II PASRR" dated 10/10/25 indicated, "Follow and care plan all recommendation(s) set forth by the PASRR contractor regarding the appropriateness of placement for the patient and any specialized services." Review of the facility's policy titled, "Care Plans" dated 01/06/20 specified, "Social Work and Discharge Planning staff will actively participate in the development of an individualized care plan that addresses, at minimum, the discharge preference, any relevant history of trauma or PTSD disclosed by the patient and Level II PASRR status, if applicable. . . The care plan must be reviewed and revised periodically (minimum of quarterly), and the services provided or arranged must be consistent with each patient's documented plan of care."	F0657		10/06/2026
F0881 SS = D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and policy review, the facility failed to implement policies and procedures to ensure antibiotics were not used without the presence of a diagnosed infection and failed to complete an infection screening evaluation for one of three residents (Resident (R) 137) reviewed for antibiotic stewardship. The failure had the potential to increase the risk of adverse events, including the development of antibiotic-resistant	F0881	F0881 - Antibiotic Stewardship Facility is unable to retroactively correct this incident as it occurred in the past. Residents with orders for antibiotics have the potential to be affected. Facility DON will audit residents with orders for antibiotics to ensure all orders are justified by a corresponding test for infection or appropriate documentation certifying the use of antibiotics is appropriate according to McGeer/SHEA/CDC criteria. Medical Director will educate Nurse Practitioners on the requirements for testing and documentation of symptoms when prescribing antibiotics, including when urine test is refused. Staff Development Coordinator, DON and ADON will educate licensed nurses on the requirements for testing and documentation when a resident is ordered antibiotics, including when a urine test is refused. Residents with orders for antibiotics will be added to the Agenda for Weekly Risk Meeting with the IDT	10/06/2026

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F0881 SS = D	Continued from page 31 organisms, resulting from unnecessary or inappropriate antibiotic use. Findings include: Review of R137's "Admission Record" located under the "Profile" tab of the electronic medical record (EMR), indicated R137 was admitted to the facility on 09/13/25. Review of R137's quarterly "Minimum Data Set (MDS)" located under the "MDS" tab with an Assessment Reference Date (ARD) of 03/13/26, revealed a "Brief Interview for Mental Status (BIMS)" score of 11 out of 15, which indicated R137 was moderately cognitively impaired. Review of R137's quarterly "MDS" located under the "MDS" tab with an ARD of 06/10/26, revealed a "BIMS" score of 3 out of 15, which indicated R137 was severely cognitively impaired. Review of R137's "Orders" located under the "Orders" tab of the EMR revealed an order for a urinalysis and culture dated 06/09/26. Review of "Progress notes" dated 06/09/26 through 06/10/26, located under the "Prog Notes" tab of the EMR, documented no behavioral concerns and contained no documentation supporting a suspected infection or the reason for ordering a urinalysis and culture. Review of R137's "laboratory results" dated 06/10/26, provided by the facility, revealed a White Blood Cell (WBC) count of 7.5, which was within the normal range. Review of R137's "Progress Notes" dated 06/11/26 at 7:24 AM, located under the "Prog Notes" tab of the EMR documented, "Patient monitored for behaviors no c/o [complaints of] noted, refused to give urine for ua-c+s [urinalysis, culture and sensitivity], NO S/S [signs or symptoms] of distress noted." Review of "hospital records" dated 06/14/26, provided by the facility, revealed R137 was evaluated	F0881	Continued from page 31 and Medical Director to ensure review of a testing and/or documentation justifying use of antibiotic has been completed and documented. Root cause identified as staff needing education on documentation for justification of antibiotics when a urine test is refused. The Administrator and/or Director of Nursing are responsible for the corrective action. Facility DON and ADON will conduct a weekly audit of residents with new orders for antibiotics to ensure required documentation of justification for use is present and complete. Once four consecutive weeks of audits demonstrate 100% compliance, the audits will be conducted monthly for an additional two months. Results of these audits will be brought to the QAPI Committee for further review and recommendations. Date of Compliance: 10/6/2026	10/06/2026

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F0881 SS = D	Continued from page 32 in the emergency room following a fall and documentation indicated, ". . . No reported infectious symptoms." There was no record a urine specimen was collected. Review of R137's "Orders" located under the "Orders" tab of the EMR, revealed an order dated 06/15/26 for Cephalexin (an antibiotic) 500 milligrams, one tablet by mouth every 12 hours for a urinary tract infection (UTI) for five days. Review of R137's "Medical Note" located under the "Prog Notes" tab of the EMR dated 06/15/26, revealed the provider did not document signs or symptoms of infection, a diagnosis of a UTI or a rationale for ordering an antibiotic. Review of the facility's "Weekly Director of Nursing Report-Infections (antibiotic stewardship line listing)" located in the infection control binder and dated 06/11/26 through 06/17/26, indicated, "R137 suspected UTI, facility acquired, and cephalexin." The facility identified R137 as having a suspected UTI; however, the line listing did not contain documentation of symptoms, laboratory results, treatment dates, or evidence the antibiotic met facility antibiotic stewardship criteria. Review of R137's June 2026 "Medication Administration Record (MAR)" located under the Orders tab of the EMR revealed Cephalexin was administered from 06/16/26 through completion of the prescribed five-day course. During an interview on 08/26/26 at 11:17 AM, the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) stated the antibiotic was ordered for R137 because of increased confusion, increased aggression, and a decline in the BIMS score from 11 to three. The ADON/IP stated, "R137 should have had an Infection Screen Evaluation initiated in the EMR and it was not completed. I would have expected the provider to document a rationale for ordering antibiotics without laboratory results. We use McGeer criteria. Review of the antibiotic ordered on 06/15/26 did not meet criteria." Review of the facility's policy titled, "Antibiotic Stewardship Program," dated 10/24/22, indicated, "The Center is committed to providing quality care	F0881		10/06/2026

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F0881 SS = D	Continued from page 33 through implementation of an Antibiotic Stewardship Program designed to promote appropriate antibiotic use and reduce antibiotic resistance. Antimicrobial therapy should be based on McGeer/SHEA/CDC criteria."	F0881		10/06/2026