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:** September 16, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from September 14, 2026, through September 16, 2026. The deficiencies contained in this report are based on observations, interviews, review of resident's clinical records and review of other facility documents as indicated. The facility census for the first day of the survey was one hundred seventy-two (172). The survey sample totaled three (3) residents.		
3201 **3201.1.0** **3201.1.2**	**Regulations for Skilled and Intermediate Care Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567 - L survey completed September 16, 2026. Cross refer: F760 and F842.	Please see Federal 2567 and POC for F-760 and F-842	10/6/26

Provider's Signature Brian Tenda LNHA Title Administrator Date 10/6/26

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 09/16/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from September 14, 2026 through September 16, 2026. The deficiencies contained in this report are based on observations, interviews, review of resident's clinical records and review of other facility documents as indicated. The facility census for the first day of the survey was one hundred seventy-two. The survey sample totaled three (3) residents. Abbreviations/definitions used in this report are as follows: AAOx1 - alert and oriented to person only;DON - Director of Nursing;EHR - Electronic Health Record;eMAR - Electronic Medication Administration Record; IM - intramuscular injection; FM - Family Member;LPN - Licensed Practical Nurse;MAR - Medication Administration Record; MD - Medical Director; MDS Assessment - federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; Milligram (mg) - unit of weights; mL - milliliter; Morphine Sulfate - an opioid concentrate medication for pain; Narcan also known as Naloxone (generic name) - medication used to reverse or reduce the effects of opioids; Opioids - a class of drugs used primarily to treat moderate - to -severe pain; overdose occurs when too much of the drug slows breathing to life - threatening levels, causing lack of oxygen to the brain, which can lead to permanent damage or death;NHA - Nursing Home Administrator;NP - Nurse Practitioner;Pulse ox (oximeter) - device used to measure blood oxygen saturation levels - desired range is 94% to 100%. RN - Registered Nurse;S/P - status post; UM - Unit Manager.	F0000		09/18/2026
F0760 SS = SQC-J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by:	F0760	"Past Noncompliance - no plan of correction required"	09/18/2026

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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F0760 SS = SQC-J	Continued from page 1 Based on interview and record review, it was determined that for one (R1) out of three residents reviewed for medication administration, the facility failed to ensure that one resident was free from a significant medication error. R1 received the incorrect dose of morphine sulfate for pain when R1 erroneously received 5 mL (milliliter) = 100 mg (milligram) of the concentrated morphine sulfate oral solution instead of the physician prescribed dose of 5 mg = 0.25 mL on 9/9/26 at 1:15 PM. R1 was at risk of a severe, life-threatening respiratory depression or death. R1 was administered Naloxone 0.4 mg/mL intramuscularly three times to reverse R1's overdosage. An immediate Jeopardy (IJ) was identified starting 9/9/26. Due to the facility's corrective measures, this is an immediate jeopardy, past non - compliance with an abatement date of 9/13/26. Findings include: A facility policy titled "General Guidelines for Medication Administration", dated September 2018, documented, "...Procedure 4. At minimum, the 5 Rights – right resident, right drug, right dose, right route, and right time – should be applied... a. Check #1: Select the medication... b. Check #2: Prepare the dose by removing the dose from the container and verifying it against the label and the MAR (Medication Administration Record) by reviewing the 5 Rights... c. Check #3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights..." Cross refer F842 Review of R1's clinical record revealed: 11/20/23 – R1 was admitted to the facility with diagnoses including but not limited to arthritis of the spine with history of right shoulder replacement and polyarthritis of the left shoulder. 11/20/23 – A care plan was developed for R1's risk for complications related to the use of Opioid secondary to arthritis and chronic pain and, interventions included administering medications as ordered. 5/13/25 – R1 had a physician's order for 5 mg (milligram) = 0.25 mL morphine sulfate (an opioid concentrate) oral solution every four hours for pain. 8/31/26 – R1's annual MDS (Minimum Data Set) assessment revealed that R1's cognition was severely impaired. R1 was dependent with eating, toileting, bed mobility and transfer. In addition, R1	F0760		09/18/2026

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F0760 SS = SQC-J	Continued from page 2 was under hospice services and was receiving opioids within the last seven days during the review period. 9/9/26 4:16 PM – A facility incident report submitted to the state reporting agency documented that a Licensed Practical Nurse [E3, LPN) administered an incorrect dose of morphine sulfate which was more than what was ordered. It further documented, "…The NP [Nurse Practitioner, P1] was in house … Narcan (medication used to reverse or reduce the effects of opioids) was given as ordered by [P1]. Oxygen was placed on the resident and vital signs monitored…[R1] is being monitored and will continue to be monitored for 24 hours… [P3, MD] notified. [P4, Hospice] notified… [FM1, Daughter] notified…" 9/9/26 2:30 PM – A nurse progress noted by E4 (RN, UM) documented, "At 1324 (1:24 PM) (sic) called to (unit) for RN assessment after nurse reported giving an incorrect dose of morphine. [R1] remained awake and alert. [P1] was at bedside with Narcan was administered. [R1] remained arousable and was responding to staff and smiling. Vital signs monitored throughout with no critical values identified. Oxygen placed at 1 L (liter) via nasal canula…" 9/9/26 3:11 PM – A late entry note by E4 documented, "On 9/9/2026 at 1330 (1:30 PM) was given a verbal order to administer Narcan 0.4 mg/ml IM (intramuscular) for incorrect dose of morphine. At 1342 (1:42 PM), received another verbal order to give second dose of Narcan 0.4 mg/ml. at 1354 (1:54 PM), received a verbal order from [P1] to administer Narcan 0.4 mg/ml." 9/9/26 – A physician encounter note by P1 documented, "Chief Complaint: Accidental medication error… Nursing notified [P1] (sic) patient [R1] was given the incorrect dose of morphine. Narcan given. Oxygen given (sic) nasal canula for support. [R1] remained conscious, smiling. [R1] is AAOx1 (alert and oriented to person only) at baseline. [R1] is on continuous monitoring… Plan: Incorrect dose of medication S/p (status post) Narcan 0.4 mg IM, on continuous monitoring…" 9/9/26 5:38 PM – A nurse progress note by E6 (LPN) documented that R1 was transferred to the hospital at 5:15 PM. 9/9/26 9:53 PM – An ED (Emergency Department) Physician Record documented, "[R1] was brought to the [ED] for evaluation because she got a higher than prescribed dose of morphine sulfate. [R1] is	F0760		09/18/2026

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F0760 SS = SQC-J	Continued from page 3 prescribed 5 mg of the 20mg/mL liquid. There is some uncertainty about exactly how much she can receive (sic) but it was reported that she received 5 times the usual dose. [R1] did receive Naloxone prior to arrival and has largely been back to baseline…" 9/10/26 3:50 AM – A nurse progress note documented that R1 returned to the facility with no new orders or recommendations. 9/10/26 - A physician encounter note by P1 documented, "Chief Complaint: ED visit…past medical history of chronic pain on morphine…[R1] was given Narcan and transferred to ED for further evaluation…[R1] was monitored in the [ED] for 4-1/2 hours post Narcan and remains awake and alert…deemed stable and return (sic) to this facility… has 1:1 for continuing monitoring… Plan: Incorrect dose of medication…S/p Narcan… will change morphine to pre-filled syringes from pharmacy…" 9/11/126 1:02 PM – R1 had a new physician's order for morphine sulfate 0.25 mL sublingually (under the tongue) every 4 hours for pain (0.25 mL = 5 mg) hold for sedation. An undated verbal statement by E3 (LPN) documented, "At approximately 1:15 (1:15 PM) I was giving [R1] her morphine. I opened a new bottle, and I incorrectly mixed up the ml and the mg and gave the wrong dose. I realized it when I returned to my cart to complete the documentation. I reported this immediately to my Unit Manager [E5]. I was behind my medication pass, and I was rushing to finish…" 9/14/26 – A facility follow up report documented that E3 misread the order that was to give 5 mg to be 5 mLs. When E3 returned to complete signing out the medication she saw the error and reported it to her UM (Unit Manager) immediately. It further documented, "…All management staff and the NP responded to [R1's] room immediately. Narcan was given as ordered by the NP. Vital signs were being monitored, and pulse ox (blood oxygen level) was continuous. [R1] was monitored by a staff. At about 4:30 pm [R1's] BP (blood pressure) dropped lower and we contacted [P3, MD] who ordered transfer to the ER… The order was put in to the [EHR, Electronic Health Record] as morphine 20 mg per ml administer 5 mg in May [2025] by [P2] …" 9/14/26 12:20 PM – In an interview, E3 stated that she was behind with her medication administration and was giving R1's 9:00 AM morphine sulfate order at 1:15 PM. E3 further stated, "I was getting [R1's] 5 mg morphine sulfate but I withdrew 5 mL of	F0760		09/18/2026

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F0760 SS = SQC-J	Continued from page 4 morphine from the bottle. I was in a hurry to think that 5 mg was not 5ml of morphine… When I realized I gave more than what was ordered, I reported it right away to [E5, UM]. 9/14/26 12:56 PM – During an interview, P1 stated that R1 received the incorrect morphine sulfate dosage. P1 further stated that R1 received three doses of Narcan and was not in any respiratory distress. P1 also stated that R1's blood pressure started to go down and that R1 was sent to the hospital for further monitoring and evaluation. 9/14/26 1:21 PM – In an interview, E5 state that E3 came up to report to her regarding R1's incorrect dosage. E3 stated that she checked R1, notified the NP and DON, and called for [E4, RN UM] to assess R1. 9/14/26 1:33 PM – During an interview, E4 stated that she was called to (unit) to assess R1 post administration of incorrect morphine sulfate dosage. E4 further stated that she was with P1 at R1's bedside when she received the verbal physician's orders from P1 to administer the two doses of Narcan intramuscular injections to R1. E4 also stated that R1's BP (blood pressure) "got a little bit below", and that she received another verbal physician's order to administer the 3rd dose of Narcan, and after 3:00 PM, R1 was transferred to the ER. The facility failed to ensure that R1 was free from significant medication administration error when R1 received 5 ml or 100mg of the concentrated morphine sulfate oral solution instead of the ordered dose of 5 mg = 0.25 ml on 9/9/26 at 1:15 PM. This resulted in a significant medication error for R1 who received 20 more doses of the morphine sulfate solution than the prescribed physician order. 9/15/26 1:03 PM - An Immediate Jeopardy (IJ) was called and reviewed with the facility leadership, including E1 (NHA) and E2 (DON). During this conference, E1 and E2 both confirmed that there had been no other incidents of significant medication error after the 9/9/26 incident. 9/15/26 – E2 (DON) presented to the surveyor an acceptable documentation of a corrective action plan that was fully abated on 9/13/26. The facility's corrective actions at the time of the incident included: 1. R1 was given the wrong dose of morphine. The error was reported immediately. The NP (nurse	F0760		09/18/2026

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F0760 SS = SQC-J	Continued from page 5 practitioner) saw R1 at bedside. Narcan was administered, and vitals were monitored as ordered by the NP. Medical Director (MD) was contacted, Hospice and R1's daughter [FM1] were notified. R1's vitals were monitored and her blood pressure was noted low. R1 was transferred to the ER and returned to the facility after a few hours with no adverse reactions. 2. Narcotic books were audited to validate all residents who receive morphine sulfate were administered the correct dose. All morphine orders were audited and corrected as needed to show the administration dose in ml's rather than mg. Pharmacy contacted to request pre-filled syringes of morphine 5 mg. 3. All nursing staff will be educated on the 5 rights of medication administration. All nursing staff will perform a return demonstration on calculating the proper morphine dose as well as pulling up doses correctly. No staff will be permitted to work without completing this training. All new hires will have to successfully pass a medication test on dosage calculation or participate in remedial training on dose calculation before orientation on the medication cart. All nurses will be monitored by an RN or Unit Manager when administering morphine for a period of two weeks. The nurse that made the error was placed back on orientation and received further training on medication calculation and successfully pass a test prior to being released to independently pass meds. Once approved to be independent, this nurse will be required to have a second nurse observe and confirm correct dosage when administering any narcotic. All doses of morphine administered will be observed by the Supervisor or unit manager for accuracy until full compliance with all audits. 4. Audits will be done shift to shift on all morphine orders to ensure accurate doses continue to be given for a period of two weeks. If 100% compliance is achieved, audits will be done in one unit per shift for a period of two weeks. If 100% compliance is achieved, audits will be done 3 times a week for a period of two weeks. If there is any discrepancy in the administration or process being followed, the audits will return daily on each shift. This plan was reviewed at QAPI. Compliance date 9/13/26. No immediate action required related to past non-compliance. This was verified by review of facility documents and interview with facility staff and residents.	F0760		09/18/2026

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F0760 SS = SQC-J	Continued from page 6 9/16/26 9:40 AM - Findings were reviewed at the exit conference with E1 (NHA).	F0760		09/18/2026
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious	F0842	F0842 Immediately upon discovery, the orders for the Narcan were put into the EMR for the resident. All residents receiving verbal orders for Nacan have the potential to be affected. A review of residents receiving Narcan in the last 30 days was conducted by Director of Nursing to ensure all orders were entered into the EMR. All files were found to be in compliance. Nurse Managers and Licensed Nurses were educated that all verbal orders for Narcan need to be entered into the EMR as soon as it is safe to do so. Residents receiving Narcan administration will be added to the Weekly Risk Meeting Agenda to ensure policies and procedures, including entering the orders into the EMR, were followed and completed. Root Cause assessed to be a need for process review after Narcan Administration. Administrator and Director of Nursing are responsible for the corrective action. Director of Nursing will conduct a weekly audit of residents who received Narcan Administration to ensure orders were entered into the EMR. The audits will continue weekly until four weeks of 100% compliance are achieved. Once achieved, 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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F0842 SS = D	Continued from page 7 threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, it was determined that for one (R1) out of three residents reviewed for medication administration, the facility failed to maintain clinical records that meet professional standards of practice. R1's verbal physician orders for three doses of Narcan were not transcribed in the EHR (Electronic Health Record). The doses of medication were administered on 9/9/26 but not signed off by the Registered Nurse in the eMAR (Electronic Medication Administration Record). Findings include: Cross refer F760 Review of R1's clinical record revealed:	F0842		10/06/2026

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F0842 SS = D	Continued from page 8 9/9/26 2:30 PM – A nurse progress note entered by E4 (RN, UM) documented, "At 1324 [1:24 PM] [sic] called to [unit] for RN assessment after nurse reported giving an incorrect dose of morphine. [R1] remained awake and alert. [P1, NP] was at bedside with Narcan was administered. [R1] remained arousable and was responding to staff and smiling. Vital signs monitored throughout with no critical values identified. Oxygen placed at 1 L [liter] via nasal canula…" 9/9/26 3:11 PM – A late entry note entered by E4 documented, "On 9/9/2026 at 1330 [1:30 PM] was given a verbal order to administer Narcan 0.4 mg [milligrams]/ml [milliliter] IM [intramuscular] for incorrect dose of morphine. At 1342 [1:42 PM], received another verbal order to give second dose of Narcan 0.4 mg/ml. At 1354 [1:54 PM], received a verbal order from [P1] to administer [a third dose] Narcan 0.4 mg/ml." 9/14/26 12:56 PM – During an interview, P1 stated that R1 received the incorrect morphine sulfate dosage. P1 further stated that she gave a verbal physician's order to E4 and that R1 received three doses of Narcan. 9/14/26 1:33 PM – During an interview, E4 stated that she was called to (unit) to assess R1 post administration of incorrect morphine sulfate dosage. E4 further stated that she was with P1 at R1's bedside when she received the verbal physician's orders from P1 to administer the two doses of Narcan intramuscular injections to R1. E4 also stated that R1's BP (blood pressure) "got a little bit below". E4 further stated that she received another verbal physician's order to administer the 3rd dose of Narcan and after 3:00 PM, R1 was transferred to the ER. 9/14/26 3:00 PM - In a joint interview with P1 and E4, P1 confirmed that she gave verbal physician orders for R1's three different doses of Narcan. E4 stated that she was with P1 when the verbal orders were given at R1's bedside. E4 further stated that she did administer the three doses of R1's Narcan intramuscularly on three different times. E4 also stated that it was a very rapid response and confirmed that the verbal orders for the three different doses were not transcribed in the EHR and did not auto-populate in R1's eMAR for E4 to sign off. 9/15/26 1:15 PM – Findings were discussed with E1 (NHA) and E2 (DON).	F0842		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
F0842 SS = D	Continued from page 9 9/16/26 9:40 AM - Findings were reviewed at the exit conference with E1.	F0842		10/06/2026