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 13, 2025

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 Annual and Complaint survey was conducted at this facility from August 4, 2025, through August 13, 2025. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and other facility documentation as indicated. The facility census on the first day of the survey was (156) one hundred fifty-six. The investigate sample (37) thirty-seven 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 was not met as evidenced by: Cross refer: to the CMS-2567-L survey completed August 13, 2025: F550, F585, F609 F628, F656, F657, F684, F689, F697, F732, F755, F757, F777, F812 and F925	Please refer to CMS-2567 and Plan of Correction for F550, F585, F609 F628, F656, F657, F684, F689, F697, F732, F755, F757, F777, F812 and F925 for plans of correction for each.	9/26/2025

Provider's Signature [signature] Title Administrator Date 9/12/2025

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 08/13/2025

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 An unannounced Emergency Preparedness survey was conducted at this facility from August 4, 2025 through August 13, 2025. The facility census was one hundred and fifty-six (156) on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		08/27/2025
F0000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from August 4, 2025 through August 13, 2025. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 156. The investigate sample totaled 37 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; AIMS - Abnormal Involuntary Movement Scale; a rating scale to measure involuntary movements of the face, mouth, trunk, or limbs known as tardive dyskinesia that sometimes develops as a side effect of long-term treatment with antipsychotic medications; BOM - Business Office Manager; Bipolar - mood disorder; CNA - Certified Nursing Assistant; Contractures - structural changes to soft and connective tissues that cause them to stiffen, tighten, and lose elasticity, leading to reduced range of motion and difficulty in movement;	F0000		08/27/2025

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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F0000	Continued from page 1 DA - Dietary Aide; DOD - Director of Dietary; DON - Director of Nursing; Dysphagia - difficulty swallowing; e.g. - for example; eMARs - electronic Medication Administration Records/list of daily and PRN medications to be administered; Enteral tube feeding (also known as a G-tube) – tube used to feed resident directly into the stomach and/or to administer medications; FM - family member; Gastrostomy - tube placed through the abdominal wall into the stomach; HA - housekeeping assistant; Hoyer lift - sling-type mechanical lift; LPN - Licensed Practical Nurse; Lupus - autoimmune disease that occurs when the body's immune system attacks its own tissues and organs; MC - Management Company; MD - Medical Doctor; MDS - federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; NHA - Nursing Home Administrator; Non-pharmacological interventions - any intervention (therapy or technique) intended to improve health or well-being that does not involve the use of any drug or medicine; NP - Nurse Practitioner; Ombudsman - impartial fact-finder who assures that individuals living in long-term care facilities licensed by the State receive quality of care and are	F0000		

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F0000	Continued from page 2 treated with dignity and respect as prescribed in the Patient Bill of Rights. They investigate complaints from residents of long-term care facilities regarding violations of these rights and advocates for improving the quality of life for residents of such facilities. Opioids - medications to treat persistent or severe pain, a controlled substance; Osteomyelitis - infection and inflammation of the bone; Polyneuropathy - a condition where skin, muscle, and organ nerves are damaged; PRN - as needed; RDCS - Regional Director Clinical Services; Residual - volume of fluid remaining in the stomach at a point in time during enteral nutrition feeding; RN - Registered Nurse; SO - State Ombudsman; SW - Social Worker; UM - Unit Manager.	F0000		
F0550 SS = E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services	F0550	F-550 The facility is unable to retroactively correct the observation for Residents R7 or the other residents noted without glasses or drinkware, nor for the residents whose rooms were entered without asking permission to enter, as these are past events. There were no ill effects noted. All residents have the potential to be affected by this deficient practice as all residents have the right to dignity in terms of privacy and meal service. The Kitchen staff were re-educated by the Dietary Director to provide drinking glasses/drinkware on resident meal trays. Employees in all departments – Including agency staff – will be re-educated by the Staff Development Coordinator on the process for entering resident rooms: including knocking and asking permission prior to entering the resident room. A daily audit of ten trays per meal, per unit for two meals per day (total of 60 trays per day) will be conducted of resident trays by Administrator or	09/26/2025

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F0550 SS = E	Continued from page 3 under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to promote resident dignity as evidenced by observations during dining and entering resident rooms without permission. Findings include: 1. Review of R7's clinical record revealed: 7/15/25 - R7 was readmitted to the facility with diagnoses including chronic respiratory failure and polyneuropathy. 7/15/25 - A quarterly MDS documented R7 as cognitively intact with a BIMS score of 15. 8/6/25 12:54 PM - R7's meal was served with a plastic aluminum sealed container of juice and a carton of milk. No cup or glass was observed on R7's meal tray. 8/7/25 8:59 AM - A breakfast meal tray was delivered to R7 with a plastic aluminum sealed container of juice and a carton of milk. No cup or glass was observed on R7's meal tray. 8/12/25 10:45 AM - During an interview, E5 (DOD)	F0550	Continued from page 3 designee to ensure glasses/drinkware are provided at all meals. Once 30 days of 100% compliance is achieved, audits will switch to weekly for an additional 60 days. Daily audits, via purposeful rounding, will be conducted by Unit Managers and Nurse Supervisors to ensure staff are entering resident rooms only after obtaining permission from the resident. The random daily audits will be conducted covering all units and all shifts. Once 30 days of 100% compliance is achieved, audits will change to weekly for an additional 60 days. All audit findings will be provided to the QAPI Committee for further review and recommendations. Date of compliance: 9/26/2025	

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F0550 SS = E	Continued from page 4 confirmed that residents are not given cups or glasses with meals. 8/13/25 12:34 PM - During an interview R7 stated, "I don't like drinking from the plastic containers that everyone touches. I would like to have a cup to use." 2. 8/6/25 11:48 AM - Observation of the Bethany Unit revealed that residents' meal trays lacked glasses or drinkware. Surveyor observed only plastic self-sealed juice cups where residents would have to pull back the aluminum cover to drink from it and paper milk cartons on the residents' meal trays. 3. Observations by the surveyor revealed the following: -8/5/25 10:09 AM - during an interview between a surveyor and an anonymous resident with the door closed, E12 (LPN) knocked, opened the door and entered the room without asking permission to enter the resident's room. -8/6/25 9:45 AM - observed a resident's call light triggered and E13 (LPN) knocked, entered room without asking permission to enter. -8/6/25 11:33 AM - observed E14 (HA) knock, state "housekeeping" and entered a room without asking permission to enter as a resident was currently in the room. -8/6/25 11:43 AM - observed E14 (HA) knock, state "housekeeping" and entered another room without asking permission to enter as a resident was currently in the room. -8/6/25 12:08 PM - observed E15 (CNA) respond to a triggered call light by walking into the room without knocking and asking permission to enter. -8/6/25 12:13 PM - observed E16 (HA) knock and walk into two residents' rooms in succession without asking permission to enter.	F0550		

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F0550 SS = E	Continued from page 5 -8/7/25 9:49 AM - observed E17 (contracted NP) walk into a resident's room without knocking and asking permission to enter. -8/7/25 10:20 AM - observed E18 (HA) knock, announce "housekeeping" and walk into a resident's room. 8/13/25 9:15 AM - During an interview, finding was reviewed with E3 (DON). Surveyor asked what is the expectation of staff before entering resident rooms, E3 stated that they should knock and ask permission before entering. 8/13/25 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (RDCS), E3, E4 (ADON) and representatives with the management company, MC1 and MC2.	F0550		
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The	F0585	F-585 Upon discovery, a grievance form was completed for this family member by the Administrator. Residents and/or representatives filing grievances have the potential to be affected and have a right to file grievances and receive a response. The Administrator will re-educate facility management team on the grievance procedure. Department Managers will then re-educate facility staff regarding the grievance procedure. Grievances will be reviewed twice per day by the Administrator and Clinical Management Team, Monday through Friday at the daily stand-up and stand-down meeting to ensure all matters requiring a grievance form are addressed, and all filed grievances are managed via the grievance procedure. The Administrator will conduct a weekly audit of all grievances to ensure any concerns are filed as grievances per policy. Once 30 days of 100% compliance is achieved, audits will decrease to monthly for an additional 60 days. Results of audits will be submitted to the QAPI Committee for further review and recommendations. Date of compliance: 9/26/2025	09/26/2025

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F0585 SS = D	Continued from page 6 grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance	F0585		

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F0585 SS = D	Continued from page 7 with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interviews and review of other facility documentation as indicated, it was determined that the facility failed to ensure that grievances and concerns received by the facility included prompt efforts to resolve problems for one (R107) out of 37 sampled residents. In addition, the facility failed to ensure that a written decision was issued to the complainant. Findings include: Review of the facility's policy titled, "Service Concerns/Grievance" effective 3/1/25 indicated: Policy: "The Administrator is responsible for ensuring that the management staff are trained in appropriately resolving in – house patient/ family service concerns and grievances at the point of service as promptly as possible. The Management staff … is charged with listening and responding to questions, needs, problems, or concerns brought to their attention by patients and/or families …Procedure: 1. … any team member receiving questions or issues of concern regarding care and/ services are to immediately respond at the point of service …2. …Grievance form is to be promptly submitted by the staff member … 3. …Manager receiving the concern actively and promptly initiates appropriate action (no later than 48 hours of receiving the concern) … 4. The Administrator will follow up as needed with patient/family … 5. …the patient may be provided written response from the Administrator." Review of R107's records revealed the following: 3/12/24 - R107 was admitted to the facility. 4/15/25 1:37 PM – An activity report by E9 (BOM) documented, " … [FM1] demanded that I met with her. She called me a liar and said I was frauding (sic) her and that I am good at my job and that I abused her…" 4/23/25 1:21 PM - An activity report by E9 (BOM)	F0585		

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F0585 SS = D	Continued from page 8 documented, " … [FM1] collected itemized bill." 5/5/25 1:01 PM - An activity report by E9 (BOM) documented, "… spoke to [FM1]…needs another copy of itemized bill…" 6/18/25 2:59 PM - An activity report by E9 (BOM) documented, " … [FM1] requested copy of itemized bill." 7/7/25 12:11 PM - An activity report by E9 (BOM) documented, " … provided itemized billing again." 7/10/25 10:33 AM - An activity report by E9 (BOM) documented, "... [FM1] wants to plan meeting to discuss payment on account. Gave my availability." 7/28/25 10:06 AM – A social worker progress note documented, " …spoke with [FM1] to reschedule business office meeting. [FM1] states that she will need to speak with the ombudsman first to reschedule (sic) financial meeting team notified." 8/1/25 5:01 PM – A social worker progress note documented, "... called [FM1] to check status of new appointment date. There was no answer, voicemail left." 8/4/25 11:00 AM – During a phone interview, FM1 told the surveyor that she has been having billing issues with the facility. FM1 stated that the facility's itemized billing was not specific. FM1 also stated that she received a statement of claims from Medicare covering the period 2/27/25 through 6/27/25 for services that her mother [R107] did not receive. FM1 stated that her mother did not use catheter supplies and knee brace that were charged in the Medicare account. FM1 stated that she already reported this to the facility a few weeks ago and have spoken to E10 (SW1). FM1 added, "She [E10, SW1] has a copy of the Medicare Statements. I also wrote a note for the BOM [E9] so she can sign and acknowledge that these were the fraudulent billing issues I wanted to get clarified as these were bothering me and causing me sleepless nights and anxiety. I have been wanting to meet with the facility's business department but I want the State Ombudsman [S1] to be there as well." 8/6/25 1:30 PM – In an interview, E9 stated, " It's an ongoing process and we were trying to set up a financial meeting to discuss the billing issues together with [FM1] and the Ombudsman on 8/19/25. It is taking that long to schedule because of the availability of the other attendees of the meeting. When asked if the facility identified the situation as a grievance concern, E9 stated, "No".	F0585		

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F0585 SS = D	Continued from page 9 8/7/25 9:59 AM – In an interview, S1 (SO) stated that she was aware of FM1's billing concerns with the facility and that the financial meeting dates were changing because of availability of the attendees. 8/7/25 10:30 AM – During an interview, when asked if a grievance report was initiated to investigate and address FM1's concerns, E1 (NHA) stated, "I am not aware. I will have to check". 8/7/25 12:40 PM – In an in person interview, FM1 presented to the surveyor a copy of the Medicare Summary Notice with indicated charges from a medical supply company for catheter and knee brace. FM1 told the surveyor that E10 (SW1) saw the statement and made a copy of it. Surveyor directed FM1 to speak with E1 and to present the Medicare Summary Notice statement of account to E1. 8/8/25 8:40 AM – In an interview, E1 told surveyor that he met with FM1 and FM2 (R107's granddaughter) to discuss the billing issues and initiated a Grievance/Concern report. 8/8/29 9:15 AM – During an interview, E10 (SW1) stated that she met with FM1 a few weeks ago and was made aware by FM1 of R107's Medicare Summary Notice statement of account. E10 stated, "No we did not identify this as grievance but we were trying to set up a meeting with FM1 and the business office to clarify the billing issues but the dates were changing because of the attendees and their availability." 8/12/25 9:00 AM – E1 presented to this surveyor a copy of the completed grievance report and resolution dated 8/11/25. Summary of investigation indicated that the facility had no knowledge or relationship with the company named on the statement. E1 notified FM2 of the findings at the request of both FM1 and FM2. 8/13/25 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (RDCS) and E3 (DON).	F0585		
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	F0609	F-609 The facility is unable to retroactively correct the observation for Resident R179, as this is a past event. Residents involved in events requiring reporting to the State have the potential to be affected by this deficient practice.	09/26/2025

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F0609 SS = D	Continued from page 10 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of clinical record and other documentation as indicated, it was determined that for one (R179) out of five residents reviewed for hospitalization, the facility failed to report to the State Agency in the five day follow-up investigation that R179 was not transferred according to the resident's care plan by E19 (CNA) and what corrective action was taken. Findings include: Cross refer to F689 Review of R179's clinical record revealed: 10/2/23 - R179 was care planned for at risk for falls with an intervention of using a Hoyer lift for transfers with two staff. 3/26/25 - The facility's investigation revealed E19's (CNA) written response that stated, "... I transferred [R179] with the hoyer lift by myself on 3/17 and 3/24...". 3/31/25 - The facility's five-day follow-up report submitted to the State Agency documented, "...Resident was transferred to the shower gurney via the Hoyer lift on scheduled days... without any incidents...". Despite having a statement from E19 that R179's plan of	F0609	Continued from page 10 Nurse Managers will be educated by the Administrator that when conducting investigations, employees directly related to the incident must be interviewed by a nurse manager rather than just providing a statement. Interviews and statements will be reviewed carefully and cross-referenced when completing State Reports and Investigation Summaries to ensure the latter are accurate to the information gleaned during the investigation. A weekly audit will be conducted by the Administrator of all reports sent to the state to ensure documentation accurately reflects the investigation. Weekly audits will continue until 90 days of 100% compliance is achieved. Results of audits will be submitted to the QAPI Committee for further review and recommendations. Date of compliance: 9/26/2025	

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F0609 SS = D	Continued from page 11 care was not followed twice, this was not identified and included in the facility's investigation, what corrective action taken, and reported to the State Agency in the five-day follow-up report. 8/13/25 3:00 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (RDCS), E3 (DON), E4 (ADON) and representatives from the management company, MC1 and MC2.	F0609		
F0628 SS = E	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's	F0628	F-628 The facility is unable to retroactively correct the observation for Residents R46, R98, R111, R167 and R179, as these are past events. Residents requiring hospitalization have the potential to be affected by this deficient practice. Social Services Staff will be educated by the Administrator to obtain a mailing address and/or email address and place it on file for all resident representatives upon admission. Social Services will audit the current resident population to ensure the list is complete and accurate. The admissions Director and Admissions Coordinator will be educated by the Administrator on completing notifications in writing to resident representatives upon hospitalization. The Social Services Department will be re-educated by the Administrator on the process for notifying Ombudsman of resident hospitalizations. A daily audit of hospitalizations will be conducted by the Administrator or designee to ensure written notifications were sent to the resident representatives. Once 30 days of 100% compliance is achieved, audits will be decreased to weekly for an additional 60 days. The Ombudsman Resident Hospitalization notifications are required monthly. Monthly audits will be conducted by the Administrator or designee to ensure all resident hospitalizations are included. Audits will continue until 90 consecutive days of compliance are achieved. Results of both audits will be submitted to the QAPI Committee for further review and recommendations. Date of compliance: 9/26/2025	09/26/2025

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F0628 SS = E	Continued from page 12 representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge;	F0628		

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F0628 SS = E	Continued from page 13 (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return-	F0628		

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F0628 SS = E	Continued from page 14 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by:	F0628		

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F0628 SS = E	Continued from page 15 Based on record review and interview, it was determined that for five (R46, R98, R111, R167, R179) out of five residents sampled for hospitalization and three residents sampled for discharge review, the facility failed to notify in writing R46, R98 and R5's representatives of the notice of transfer to the hospital. In addition, the facility failed to notify the State Ombudsman of R46's transfer to the hospital. Findings include: The following residents were transferred to the hospital for emergent medical needs: 1. Review of R46's record revealed: 1a. R46 was transferred emergently to the hospital and was admitted on 2/1/25 and 4/12/25. 8/12/25 1:00 PM - A review of R46's records lacked evidence that R46's representative was notified in writing of R46's transfer to the hospital on both dates. 8/12/25 2:20 PM – In an interview, E3 (DON) confirmed that the facility lacked evidence that written notices of hospital transfer were sent to R46's representative when she was transferred to the hospital on 2/1/25 and 4/12/25. 1b. 8/12/25 1:15 PM – Review of the facility's April 2025 Transfer Log lacked evidence that the Ombudsman was notified of R46's transfer to the hospital on 4/12/25. 8/12/25 2:21 PM - In a follow up interview, E3 confirmed that the Ombudsman was not notified of R46's hospital transfer on 4/12/25. 2. Review of R98's clinical record revealed: 4/28/25 – R98 was transferred emergently to the hospital and was admitted. 8/12/25 1:56 PM - A review of R98's records lacked	F0628		

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F0628 SS = E	Continued from page 16 evidence that R98's representative was notified in writing of R98's transfer to the hospital. 8/12/25 2:22 PM – In an interview, E3 (DON) confirmed that the facility lacked evidence that a written notice of hospital transfer was sent to R98's representative when she was transferred to the hospital on 4/28/25. 8/12/25 2:33 PM – Findings were discussed with E2 (RDCS) and E3 (DON). 3. Review of R111's clinical record revealed: 7/22/25 - R111 was transferred to the hospital from the facility. 8/12/25 - A review of R111's records lacked evidence that R111, or their representative, was notified in writing of the transfer to the hospital. 8/12/25 2:20 PM – In an interview, E3 (DON) confirmed that the facility lacked evidence that written notice of hospital transfer was sent to R111, or their representative, when he was transferred to the hospital on 7/22/25. 4. Review of R167's clinical record revealed: 5/26/25 – R167 was transferred to the hospital from the facility. 8/12/25 – A review of R111's records lacked evidence that R167, or their representative, was notified in writing of the transfer to the hospital. 8/12/25 2:21 PM - In an interview, E3 (DON) confirmed that the facility lacked evidence that written notice of hospital transfer was sent to R167, or their representative, when he was transferred to the hospital on 5/26/25. 5. Review of R179's clinical record revealed:	F0628		

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F0628 SS = E	Continued from page 17 R179 was sent to hospital on 3/25/25. The facility lacked evidence of a notice of transfer to R179's representative. 8/13/25 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (RDCS), E3 (DON), E4 (ADON) and representatives with the management company, MC1 and MC2.	F0628		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F0656	F-656 Immediately upon discovery, care plans for Residents R22 and R153 were updated to include potential complications of gastronomy tube blockage and dislodgement and non-pharmacological pain interventions, respectively by the Unit Manager. Residents with gastronomy tubes and residents on opioids for pain have the potential to be affected by this deficient practice. Licensed Nurses – including agency staff – will be re-educated by Staff Development Coordinator on ensuring Care Plans address interventions for potential complications of gastronomy tube blockage and dislodgement and non-pharmacological pain interventions for pertinent residents. An audit will be conducted by QA Nurse and/or designee of residents with gastronomy tubes and opioid orders to ensure their care plans are complete and specialized. This will start with a full audit of in-house residents and continue daily/as-needed for new residents and residents with new orders. Once 30 days of 100% compliance is achieved, audits will decrease to weekly for an additional 60 days. The results of audits will be submitted to the QAPI Committee for further review and recommendations. Date of compliance: 9/26/2025	09/26/2025

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F0656 SS = D	Continued from page 18 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for two (R22, R153) out of 37 residents reviewed for care plans, the facility failed to develop a comprehensive person-centered care plan for each resident that addressed each resident's medical needs. Findings include: 1. R22's clinical record revealed: 7/8/25 - R22 was admitted to the facility with diagnoses that included, but were not limited to, a stroke, dysphagia and gastrostomy. 7/12/25 - R22 was care planned for at risk for complications related to the need for an enteral tube feeding. Review of the care plan lacked evidence of approaches for tube blockage and dislodgment. 8/13/25 8:00 AM - During an interview, E4 (ADON) was asked if R22's care plan approaches addressed potential complications of gastrostomy tube blockage and dislodgment. E4 reviewed R22's care plan and acknowledged that the care plan did not include these approaches. 2. R153's clinical record revealed: 6/19/25 – R153 was admitted to the facility with diagnoses that included, but were not limited to, lupus	F0656		

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F0656 SS = D	Continued from page 19 and chronic pain. R153 had two care plans that addressed her pain, including: 6/20/25 – Risk for pain related to recent hospitalization and recent fall at home; and 7/8/25 – OPIOIDS…at risk for complications. R153's pain care plans lacked evidence of non-pharmacological interventions for pain management. 8/13/25 9:15 AM – During an interview, finding was reviewed with E3 (DON). No further information was provided to the surveyor prior to exit conference. 8/13/25 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (RDCS) and E3 (DON).	F0656		
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 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	F0657	F-657 Immediately upon discovery, Resident R25's Care Plan was updated by Assistant Director of Nursing (ADON). Residents with newly identified needs that will require an update to the plan of care have the potential to be affected. Licensed Nurses – including agency staff – will be re-educated by Staff Development Coordinator to notify a Nurse Manager or Supervisor when a resident has a new need so the care plan can be updated, and to report this change in need to oncoming shifts via report. Nurse Managers will be educated by the DON that the care plan must be updated upon notification of a resident having a new need to address identified resident needs promptly upon the needs being identified. An audit will be conducted by the QA Nurse and/or designee on residents with newly identified, and new residents to ensure their care plans are complete and specialized. This will start with a full audit of in-house residents and continue daily/as-needed for new residents and residents with newly identified needs.	09/26/2025

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 08/13/2025

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

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F0657 SS = D	Continued from page 20 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 observation, interview, and record review it was determined that for one (R25) out of thirty–seven sampled residents, the facility failed to review and revise the care plan to reflect an identified need. Findings include: Review of R25's clinical record revealed: 12/24/23 – R25 was admitted to the facility with diagnoses including bipolar disorder, anxiety disorder and major depressive disorder. 12/24/23 - A care plan was developed for R25's history of behaviors related to bipolar disorder ... and suicidal threats with interventions including but not limited to needed referrals for psyche services (12/24/23) ... and behavior contract (12/13/24). 10/30/24 2:14 PM – A psyche note documented "... Facility requested to see patient r/t (related to) her feeling that she did not want to live anymore therefore she took her oxygen off. After being engaged with her mother, she did agree to wear her oxygen back on." 7/22/25 12:47 PM – A psyche note documented " ... This writer was asked to see resident who had been refusing medication, expressing feelings of hopelessness, and reporting a desire to die. Resident presented in crisis and was very emotional and distraught." 7/31/25 5:57 PM – An ER (Emergency Room) visit note documented that resident was seen in the ER for suicidal ideation." 8/4/25 2:00 PM – A psyche note documented " ... This writer was asked to see resident who was sent to the ER last week due to suicidal threats." 8/8/25 3:00 PM - A review of R25's behavior care plan lacked evidence that R25's interventions were revised to address her recurring suicidal ideation.	F0657	Continued from page 20 Once 30 days of 100% compliance is achieved, audits will decrease to weekly for an additional 60 days. Results of audits will be submitted to the QAPI Committee for further review and recommendations. Date of compliance: 9/26/2025	

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F0657 SS = D	Continued from page 21 8/11/25 12:05 PM – In an interview, E3 (DON) confirmed that R25's care plan interventions for suicidal threats were not revised. 8/13/25 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (RDCS) and E3 (DON).	F0657		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, it was determined that for two (R111 and R110) out of 37 residents sampled for investigation, the facility failed to ensure that residents received care and services in accordance with professional standards of practice, the comprehensive person centered care plan, and physician orders. For R111 the facility failed to implement discharge orders for vascular surgery follow up appointment for a surgical wound. For R110 the facility failed to collaborate with Hospice for the development, implementation, and revision of the coordinated plan of care for a resident receiving hospice services. 1. R111's clinical record revealed: 7/7/25 – R111 was admitted to the facility with diagnoses including, but not limited to, an infection of the amputation stump on the left lower extremity. 7/7/25 – A review of R111's discharge orders showed instructions to follow-up with Vascular Surgery Service within 2–7 days. 7/15/25 – A wound care progress note documented: "Left BKA site with increased depth and softening of eschar. No odor or warmth appreciated on exam. Recommending follow-up with vascular surgeon." 7/22/25 – A wound care progress note documented: "Left	F0684	F-684 The facility is unable to retroactively correct the observation for Residents R-110 as the resident no longer resides in the facility. The facility is unable to retroactively correct the observation for Residents R-111 as the resident no longer resides in the facility. Residents who have admitted to the facility from the hospital have the potential to be affected by this deficient practice. Residents receiving hospice services have the potential to be affected by this deficient practice. Nurse Managers will be educated by the Director of Nursing that review of all new admissions and readmissions for recommended follow-ups listed in the hospital discharge paperwork. Follow-ups will be reviewed by the patient's Attending Physician/Nurse Practitioner to determine priority and necessity. Appointments will be assigned to the Unit Manager and Unit Clerk to ensure they are scheduled. Scheduled follow-ups and appointments will be noted in the resident chart and in appointment binder. Follow-ups and appointments will be discussed daily Monday-Friday in Stand-up and Stand-down meetings. Hospice Staff, Social Services Staff, and Licensed Nurses – including agency staff – will be educated by the Staff Development Coordinator on ensuring Hospice Care Plans are completed, updated, integrated, and accessible. The facility QA Nurse and/or designee will audit all new-admissions going back 60-days to ensure follow-ups noted in the hospital discharge paperwork have been completed for residents still in-house. The QA Nurse and/or designee will conduct daily audits of newly admitted residents for follow-up appointments to ensure they are scheduled. Once 30 days of 100% compliance is achieved, audits will decrease to weekly for an additional 60 days. Audits will be kept in Survey Audit binder. The QA Nurse and/or designee will audit residents on	09/26/2025

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F0684 SS = D	Continued from page 22 BKA site with increased depth and softening of eschar. No odor or warmth appreciated on exam. Recommending follow-up with vascular surgeon. Unit manager attempted to facilitate an appointment last week." 7/22/25 – Another wound care progress note stated: "Left BKA/stump site with increased depth and softening of eschar with new warmth and increased erythema (redness). Site includes medial (toward middle) and proximal (closer to body) wounds. Requesting patient be sent to ER for evaluation… Patient to be sent out (to the hospital)." 7/22/25 – A facility-reported incident documented: "Resident transferred to hospital this date related to increased redness of left below the knee amputation surgical site… on the 7/15/25 wound care provider visit when redness was initially assessed, a recommendation was made to schedule a visit with the vascular surgeon. E8 (unit clerk) was tasked with scheduling the appointment. As of 7/22/25, the appointment had not been scheduled and the surgical wound demonstrated further increased redness." 8/12/25 – No documentation was found that E8 had attempted to schedule the vascular surgery follow-up appointment as ordered. 8/12/25 – Interview with E1 (NHA) confirmed the facility's failure to schedule the vascular surgery follow-up appointment as per discharge orders. 2. R110's clinical record revealed: 7/11/25 – R110 admitted to the facility with diagnoses including, but not limited to, chronic obstructive pulmonary disease and chronic congestive heart failure. 8/1/25 – R110 was admitted into hospice services. 8/6/25 – A review of R110's hospice care plan revealed a stated focus, "The resident is receiving hospice services and is not expected to improve in condition for diagnosis of CHF (Chronic Heart Failure)." The goal was documented as, "The resident's care needs will be met, and they will be as comfortable as possible through review period." The intervention listed was, "See Hospice plan of care." 8/6/25 11:00 AM – An interview with E32 (LPN) confirmed that nursing staff can access the hospice care plan in the resident's hospice binder. 8/6/25 11:24 AM – The surveyor requested R110's hospice	F0684	Continued from page 22 Hospice Services to ensure their care plans are readily available on each unit and the care plans are integrated into the facility care plans. The QA Nurse and/or designee will continue audits weekly to ensure care plans for both residents newly admitted to hospice and residents on hospice with changes are compliant. Weekly audits will continue until 100% compliance is achieved. Results of all audits will be submitted to the QAPI Committee for further review and recommendations. Date of compliance: 9/26/2025	

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F0684 SS = D	Continued from page 23 binder, which staff stated housed the hospice plan of care. The binder was not available at the nurse's station. When the binder was located, it was empty and contained no hospice plan of care. 8/6/25 12:25 PM – During an interview, E10 (LSW) stated, "That is usually found in the hospice binder." E10 and the surveyor reviewed the hospice binder together, but no care plan documents were found. E10 then stated, "We use our own facility care plan, which should include the hospice care plan." A review of R110's facility-generated comprehensive care plan revealed no evidence that the hospice plan of care had been incorporated into the resident's care plan or that the facility collaborated with hospice staff to ensure the resident's end-of-life needs and interventions were addressed. 8/6/25 12:40 PM – An interview with E3 (DON) confirmed the hospice plan of care was expected to be kept current and available in the hospice binder for staff reference. E3 stated, "The hospice nurses usually update the binder, and then we make changes as needed, but I see the binder is missing information, so that should have been addressed." The facility's failure to ensure the hospice plan of care was available and integrated into the comprehensive care plan resulted in staff not having access to up-to-date goals and interventions for R110's hospice needs. 8/13/25 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (RDCS), and E3 (DON).	F0684		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by:	F0689	F-689 The facility is unable to retroactively correct the observation for Resident R-179 as this is a past event. Employee E19 will be provided additional education by the Staff Development Coordinator. All residents requiring the use of the Hoyer Lift have the potential to be affected. All nursing staff – including agency staff – will be re-educated by the Staff Development Coordinator on the use of the Hoyer Lift and policies and procedures relating to safe use of lifts. Education will include return demonstration. The facility QA Nurse and/or designee will conduct an	09/26/2025

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F0689 SS = D	Continued from page 24 Based on interview and review of the clinical record review and other documentation as indicated, it was determined that for one (R179) out of five residents reviewed for hospitalization, the facility failed to follow the plan of care requiring two staff with a Hoyer lift for transfers. Findings include: Cross refer to F777 R179's clinical record revealed: 10/2/23 - R179 was admitted to the facility with diagnoses that include, but were not limited to, traumatic brain injury and multiple contractures. 10/2/23 - R179 was care planned for at risk for falls with an intervention of using a Hoyer lift for transfers with 2 staff. 3/17/25 - R179's annual MDS assessment documented that R179 was non-verbal, rarely understood and understands, and dependent on staff for activities of daily living (showers, hygiene, dressing, rolling left and right in bed). 3/25/25 8:19 AM - The facility reported to the State Agency that R179 was sent to the hospital for evaluation after having increased drainage from the resident's left hip wound and an x-ray was ordered to rule out osteomyelitis. The 3/24/25 x-ray results showed a lateral dislocation of R179's left hip. The facility's investigation revealed E19's (CNA) written response that stated, "...I transferred [R179] with the hoyer lift by myself on 3/17 and 3/24...". 8/12/25 10:48 AM - During an interview, E19 (CNA) confirmed that she transferred R179 by herself using the Hoyer lift twice. E19 stated that she was educated. 8/12/25 11:19 AM - During a combined interview with E3 (DON) and E4 (ADON), surveyor requested evidence of the facility's education of E19. 8/12/25 - The facility lacked documented evidence of	F0689	Continued from page 24 audit of Hoyer Lift use to ensure staff are following policies and procedures. The QA Nurse will observe 3 Hoyer Lift transfers per day for 30 days. Once 30 consecutive days of 100% compliance are achieved, audits will decrease to 5 Hoyer Lift transfer observations will be completed per week for 60 days. All audit results will be submitted to the QAPI Committee for further review and recommendations. 5. Date of compliance: 9/26/2025	

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F0689 SS = D	Continued from page 25 E19's education. However, the surveyor was provided with a signed statement that was obtained by E19 on this date (8/12/25) documenting that she received education from E20 (former UM/LPN) on 3/26/25. E3 (DON) stated that E19's signed statement obtained today would be placed in her personnel file. 8/13/25 3:00 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (RDCS), E3, E4 and representatives with the management company, MC1 and MC2.	F0689		
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R153) out of two residents reviewed for pain, the facility failed to ensure non-pharmacological interventions were attempted prior to using pain medication. Findings include: R153's clinical record revealed: 6/19/25 - R153 was admitted to the facility with diagnoses that included, but were not limited to, lupus and chronic pain. 6/19/25 - A physician's order documented, "Administer non-pharmacological pain intervention as applicable. Use the key below to document the non-pharm used, 1. Propped and reposition resident for comfort. 2. Music/Television of interest as appropriate. 3. Basic/Simple message. 4. Distraction/Diversional activities. 5. Reduce stimulation: Dim light/reduce noise. 6 Bed rest if sitting up for extended period. 7. Reminiscence/guided imagery. e. Effective. n. Not effective every shift for Pain. Enter the Number of non-pharm intervention used and whether it was effective or not (e.g. 2n - This means Music was used as an intervention but not effective)."	F0697	F-697 The facility is unable to retroactively correct the observation for Residents R-153 as this is a past event. No adverse outcomes were noted. All residents receiving pain medications have the potential to be affected. An audit will be conducted by the Director of Nursing on all residents receiving pain medications to ensure non-pharmacological interventions are in place in each resident's orders and care plans. The licensed Nurses – including agency staff – will be re-educated by the Staff Development Coordinator on implementing and documenting non-pharmacological interventions for residents prior to administering pain medication. The pain medication order set in Point Click Care (PCC) will be updated to prompt nurses to document the non-pharmacological intervention used as part of the pain medication administration record. The facility QA Nurse and/or designee will audit 10 records per day of residents receiving pain medications to ensure non-pharmacological interventions were attempted and documented prior to administering pain medications. Audits will continue for 30 days until 30 consecutive days of 100% compliance are achieved. After this, audits will decrease to 10 records per week for 60 days. Results of audits will be submitted to the QAPI committee for further review and recommendations. Date of compliance: 9/26/2025	09/26/2025

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F0697 SS = D	Continued from page 26 Review of R153's eMARs from June, July and August 2025 revealed: -from 6/19/25 to 6/30/25, R153 received 22 doses of oxycodone PRN pain medication. Out of 33 opportunities, nursing staff failed to follow the physician's order as written by not documenting the specific intervention that was used and whether or not the non-pharmacological intervention was effective. -from 7/1/25 to 7/11/25, R153 received 22 doses of oxycodone PRN pain medication. Out of 31 opportunities, nursing staff failed to follow the physician's order as written by not documenting the specific intervention that was used and whether or not the non-pharmacological intervention was effective. -from 7/21/25 to 7/31/25, R153 received 21 doses of oxycodone PRN pain medication. Out of 31 opportunities, nursing staff failed to follow the physician's order as written by not documenting the specific intervention that was used and whether or not the non-pharmacological intervention was effective. -from 8/1/25 to 8/8/25, R153 received 21 doses of oxycodone PRN pain medication. Out of 22 opportunities, nursing staff failed to follow the physician's order as written by not documenting the specific intervention that was used and whether or not the non-pharmacological intervention was effective. 8/13/25 9:15 AM - During an interview, the facility's failure to use non-pharmacological interventions before administering pain medication was reviewed and acknowledged with E3 (DON). 8/13/25 3:00 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (RDCS), E3 (DON), E4 (ADON) and representatives of the management company, MC1 and MC2.	F0697		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information.	F0732	F-732 Upon discovery, the correct form with all required information was posted in the appropriate areas by the	09/26/2025

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F0732 SS = C	Continued from page 27 §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, it was determined that for eight out of eight days on survey, the facility failed to post nurse staffing information on a	F0732	Continued from page 27 staffing scheduler. All residents have the potential to be affected by this deficient practice as all residents have the right to access the information on this form. The Administrator will re-educate the staffing scheduler and HR Director on requirements for postings. Staffing Scheduler is responsible for posting these daily and for assigning to a Supervisor on weekends. The Administrator will audit the daily staffing postings daily for 90 days to ensure all information is included. Audits will continue until 90 consecutive days of 100% are achieved. Results of the audits will be submitted to the QAPI committee for further review and recommendations. Date of compliance: 9/26/2025	

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F0732 SS = C	Continued from page 28 daily basis that included, but was not limited too, the resident census and the total number of hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift. Findings include: 8/4/25 through 8/13/25 - Observation and review of the facility's daily nurse staffing posting lacked evidence of the resident daily census and the total number of hours worked by licensed and unlicensed nursing staff per shift. 8/13/2025 10:50 AM - During an interview, finding was reviewed with E1 (NHA). 8/13/25 at 3:00 PM - Finding was reviewed during the exit conference with E1, E2 (RDCS), E3 (DON), E4 (ADON) and representatives with the management company, MC1 and MC2.	F0732		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F0755	F-755 The facility is unable to retroactively correct the observation for Resident 153, as it is a past event. There were no ill effects noted. All residents receiving narcotics have the potential to be affected. An initial audit of residents currently receiving narcotics was completed by QA Nurse to ensure the medication is documented on the Medication Administration Record (MAR) and on the controlled medication count sheet. The Staff Development Coordinator re-educated licensed Nurses – including agency staff – on medication administration documentation. The facility QA Nurse and/or designee will complete audits of ten residents per day to verify administered controlled substances had the proper administration documentation daily for 30 days. Once 30 consecutive days of 100% compliance are achieved, audits will decrease to 10 residents per week weekly for 60 days. Results of audit will be submitted to the QAPI Committee for further review and recommendations. Date of compliance: 9/26/2025	09/26/2025

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 08/13/2025

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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F0755 SS = D	Continued from page 29 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R153) out of two residents reviewed for pain, the facility failed to ensure the resident's oxycodone and ativan, both controlled medications, were dispensed and recorded accurately. Findings include: The facility's pharmacy policy and procedure entitled Controlled Substance Disposal, revised 08/2020, stated, "Medications classified as controlled substances by the Drug Enforcement Administration (DEA) are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal and state laws and regulations... 2. When a dose of a controlled substance is removed from the container for administration... not given for any reason... It is destroyed in the presence of two licensed nursing personnel... and the disposal is documented on the accountability record on the line representing that dose... 3. All controlled substances remaining in the facility after a resident has been discharged or an order discontinued are disposed of: a. In the facility by the Director of Nursing and consultant pharmacist (or other licensed personnel as permitted by state regulations)... 4. Disposition is documented on the facility's Drug Destruction log or similar form...". R153's clinical record revealed: 1a. 6/20/25 - A physician's order prescribed R153 ativan medication every 12 hours as needed for anxiety. Review of R153's June and July 2025 eMARs (electronic Medication Administration Records) and the ativan controlled substance accountability record revealed the following discrepancies: -6/21/25 9:00 AM, E21 (LPN) did not record administration on the eMAR; -6/22/25 9:00 AM, E21 (LPN) documented "Wasted" on the accountability record with no evidence of two licensed	F0755		

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F0755 SS = D	Continued from page 30 nurses witnessing the disposal. -6/22/25 7:47 PM, E22 (agency LPN) did not record administration on the eMAR. -6/25/25 7:43 PM, E23 (RN) did not record administration on the accountability record. -7/3/25, E24 (LPN) recorded two different administration times, 8:00 AM on the accountability record and 12:57 PM on the eMAR. -7/4/25, E25 (agency RN) recorded two different administration times, 12:45 AM on the eMAR and 5:18 AM on the accountability record. -7/10/25 6:00 PM, E26 (LPN) did not record administration on the eMAR. 7/17/25 - The Ativan physician's order was discontinued. 7/29/25 8:00 PM - Despite the discontinuation of R153's ativan physician order, E22 (agency LPN) administered and recorded it on the accountability record. 1b. 6/19/25 - A physician's order prescribed R153 oxycodone medication every 6 hours as needed for pain and was reordered on 7/21/25 after the resident was hospitalized from 7/11/25-7/21/25. Review of R153's June, July and August 2025 eMARs and the oxycodone controlled substance accountability record revealed the following discrepancies: -6/20/25 4:00 PM, E22 (agency LPN) did not record the administration on the eMAR. -6/21/25 1:00 AM, E22 (agency LPN) did not record the administration on the eMAR. -6/21/25 9:00 AM, E21 (LPN) did not record the administration on the eMAR. -6/22/25 1:00 PM, E21 (LPN) did not record the administration on the eMAR. -6/22/25 9:00 PM, E22 (agency LPN) did not record the administration on the eMAR.	F0755		

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F0755 SS = D	Continued from page 31 -6/24/25 3:52 PM, E26 (LPN) did not record the administration on the eMAR. -7/4/25, E25 (agency RN) recorded two different administration times, 11:00 PM on the accountability record and 5:21 AM on 7/5/25 on the eMAR. -7/10/25 6:00 PM, E26 (LPN) did not record the administration on the eMAR. -7/22/25 6:35 AM, E27 (RN) did not record the administration on the eMAR. -7/25/25 8:08 AM, E28 (LPN) did not record the administration on the eMAR. -7/28/25 8:40 AM, E29 (agency LPN) did not record the administration on the eMAR. -7/28/25 4:00 PM, E22 (agency LPN) did not record the administration on the eMAR. -7/28/25 10:00 PM, E22 (agency LPN) did not record the administration on the eMAR. -7/29/25 7:00 PM, E22 (agency LPN) did not record the administration on the eMAR. -7/30/25 2:00 PM, E12 (LPN) did not record the administration on the eMAR. -8/1/25 8:00 PM, E22 (agency LPN) did not record the administration on the eMAR. -8/2/25, E22 (agency LPN) recorded two different administration times, 2:00 AM on the accountability record and 6:03 AM on the eMAR. 8/8/25 1:40 PM - During an interview, E12 (LPN) showed the surveyor two blister packs, oxycodone and ativan, that were in the medication cart's locked box. R153's ativan medication blister pack was still in the medication cart locked box despite it being discontinued on 7/17/25. When asked what is the process of discarding controlled substance medications, E12 stated that she would give them to the supervisor and they would discard it together. E12 also stated that it is the practice to record administration of ativan and oxycodone in both the eMAR and the accountability record at the same time. 8/8/25 at 1:44 PM - During an interview, surveyor	F0755		

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F0755 SS = D	Continued from page 32 reviewed findings with E4 (ADON). Also confirmed the date of 7/29/25 documented by E22 (agency LPN) when Ativan was administered after the physician's order was discontinued. 8/13/25 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (RDCS), E3 (DON), E4 (ADON) and representatives from the management company, MC1 and MC2.	F0755		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §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- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, it was determined that for one (R25) out of five residents sampled for medication review, the facility failed to ensure that R25 was adequately monitored for side effects of antipsychotic medications. Findings include: Review of R25's clinical record revealed:	F0757	F-757 The facility is unable to retroactively correct the observation for Resident R25 as this is a past event. An AIMS Assessment was completed on 7/24/25 by Staff RN. This Assessment was present in the Electronic Medical Record at the time of survey but was outside the required timeframe for AIMS Assessment for this resident. All residents ordered antipsychotic medications have the potential to be affected by this deficient practice. The facility had identified this as an area for correction prior to State Survey and has implemented a change in policy whereby all residents AIMS Assessments are updated in January and July. New residents will have an AIMS assessment completed upon admission and every January and July thereafter. Residents with a change in dosage will receive a new AIMS assessment upon change, and every January and July thereafter. The Nurse Managers will be educated by the Director of Nursing on completing AIMS Assessments for residents according to the above schedule. AIMS Assessments will be present in the Assessments Tab in the Electronic Medical Record (Point Click Care). The facility QA Nurse and/or designee will audit all residents ordered antipsychotic medications to ensure a current AIMS Assessment is present. The QA Nurse and/or designee will conduct a weekly audit of new residents with antipsychotic orders and residents with antipsychotic dosage changes to ensure a new AIMS assessment is completed. Audits will continue for 90 days until 100% compliance is achieved for 90 consecutive days. In January of 2026, the QA Nurse will ensure 100% of residents with antipsychotic orders have AIMS Assessments completed and this audit will be filed with the above listed audits. Audits will be submitted to the QA Committee for further review and recommendations.	09/26/2025

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F0757 SS = D	Continued from page 33 12/24/23 - R25 was admitted to the facility. 12/24/23 – A care plan was developed for R25's antipsychotic use and its risk for adverse reactions secondary to diagnosis of bipolar. R25's interventions included, "AIMS assessment as indicated". 6/19/25 - A Consultant Pharmacist Recommendations to Nursing revealed, "Category: Antipsychotic therapy recommendation. Resident is currently receiving antipsychotic therapy with Seroquel and requires an AIMS assessment at baseline every 6 months while on antipsychotic therapy. The last AIMS assessment in his chart is from 8/8/24. Please update." 7/4/25 - The Nursing Staff, E3 (DON), signed and documented "Done 7/6/25" per the pharmacy recommendation. 8/11/25 9:38 AM - Review of R25's May 2025 through August 2025 eMAR (Electronic Medication Administration Record) revealed that R25 continued to receive the antipsychotic Seroquel. 8/11/25 12:05 PM – E3 (DON) presented to this surveyor a copy of R25's completed AIMS assessment dated 7/24/25. E2 (DON) further confirmed that R25's AIMS assessment was "only completed after the pharmacist's July 2025 recommendation and that moving forward, the assessments will be done quarterly." 8/13/25 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (RDCS) and E3 (DON).	F0757	Continued from page 33 Date of compliance: 9/26/2025	
F0777 SS = D	Radiology/Diag Srvcs Ordered/Notify Results CFR(s): 483.50(b)(2)(i)(ii) §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is NOT MET as evidenced by:	F0777	F-777 The facility is unable to retroactively correct the observation for Resident R179 as this is a past event. All residents requiring radiology services have the potential to be affected by this deficient practice. The Licensed Nurses – including agency staff – will be re-educated by the Staff Development Coordinator on the policy and procedure for notifying the physician of radiology results, including notifying oncoming shifts of pending radiology results via the Report Process. Radiology results will be reviewed at Daily Clinical Stand-up and Stand-down meetings by Nurse Managers. The facility QA Nurse and/or designee will complete a weekly audit of x-rays completed to ensure physician was notified. Weekly audits will continue for 90 days	09/26/2025

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F0777 SS = D	Continued from page 34 Based on interview and record review, it was determined that for one (R179) out of three residents reviewed for hospitalizations, the facility failed to promptly notify the on-call provider of R179's abnormal x-ray results on 3/24/25. Findings include: R179's clinical record revealed: 3/24/25 - A physician's order documented, "Xray of left hip to r/o [rule out] osteomyelitis...". 3/24/25 4:15 PM - A nurse's note documented, "Xray completed at around 1530 [3:30 PM] hrs [hours]. Results still pending at this time. Oncoming nurse aware for a follow up." 3/24/25 7:55 PM - R179's Xray results report revealed that he had a "... dislocation of left hip...". 3/25/25 8:41 AM - A nurse's note documented, "Writer was informed by charge nurse that [E30, contracted NP] has given an order to transfer resident to the ER for further evaluation related to 3/24/25 Left hip x-ray showing a lateral dislocation of the left hip...". 8/12/25 10:10 AM - During an interview, E31 (RN) stated that it is the charge nurse's responsibility to follow-up on obtaining and notifying the on-call provider of x-ray results. 8/12/25 at 10:20 AM - During an interview, E30 stated that she was working until 8:00 PM on 3/24/25 and she did not receive any call about R179's abnormal x-ray results. E30 stated that she requested the message center call log today to see if a call was made after 8:00 PM on 3/24/25. No further information was provided to the surveyor prior to the exit conference. 8/13/25 3:00 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (RDCS), E3 (DON), E4 (ADON) and representatives of the management company, MC1 and MC2.	F0777	Continued from page 34 until 90 days of 100% compliance are achieved. Results of audits will be submitted to the QAPI Committee for further review and recommendations. Date of compliance: 9/26/2025	
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary	F0812	F-812	09/26/2025

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F0812 SS = F	Continued from page 35 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: Based on observations and interview, the facility failed to timely dispose of dry food storage, ensure proper food handling practices, and maintain sanitary conditions. Findings include: 1. Initial and subsequent kitchen tours revealed: 8/4/25 9:20 AM - Two containers of cake icing were observed in dry storage room shelf labeled 4/29. 8/6/25 9:31 AM - Two containers of cake icing were observed in dry storage room shelf labeled 4/29. 8/13/25 8:41 AM - Two containers of cake icing were observed in dry storage room labeled 4/29. 8/13/25 8:41 AM - During an interview, E5 stated "We get rid of opened containers after two months. 4/29 means these containers were opened on April 29th of	F0812	Continued from page 35 There were no residents negatively affected related to this observation. All residents receiving nourishment from the kitchen have the potential to be affected by this deficient practice. The Dietary Staff will be re-educated by the Regional Dietary Manager on the policies and procedures for food storage, disposal of expired food, hair/beard nets, and kitchen cleaning. Dietary Supervisors and designees will be educated on their responsibility to enforce these policies on each shift. The Administrator and Dietary Director will conduct daily rounds of kitchen to audit proper sanitation standards. Audits will continue daily for 30 days until 30 days of 100% compliance are achieved. After this, audits will decrease to weekly for 60 days until 60 days of weekly audits show 100% compliance. Results of the audits will be submitted to the QAPI Committee for further review and recommendations. Date of compliance: 9/26/2025	

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F0812 SS = F	Continued from page 36 this year." The opened cake icing containers were stored in the kitchen dry food pantry for over 3 months. 2. Initial and subsequent observations of food preparation revealed: 8/4/25 9:20 AM - E6 (DA) was observed not wearing a beard cover while spooning food into serving cups. 8/6/25 9:31 AM - E6 was observed not wearing a beard cover while spooning food into serving cups. E7 (DA) was observed not wearing a hairnet or beard cover while slicing meat. 8/6/25 9:31 AM - During an interview, E5 (DOD) confirmed E6 and E7 were not wearing a hair net or beard covers. 8/13/25 8:41 AM - E6 was observed not wearing a beard cover while spooning food into serving cups. 3. Observations revealed the following: 8/6/25 9:31 AM – During a kitchen tour with E5 (DOD), the surveyor observed the floor was sticky and some small debris and trash were scattered around. 8/13/25 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (RDCS), E3 (DON), E4 (ADON) and representatives with the management company, MC1 and MC2.	F0812		
F0925 SS = F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, the facility failed to ensure the kitchen dry food storage room was free of pests. Findings include:	F0925	F-925 There were no residents negatively affected related to this observation. All residents receiving nourishment from the kitchen have the potential to be affected by this deficient practice. The facility has a current pest control contract with the exterminator to ensure the kitchen is free of pests. Exterminator is on site once per month and as needed. All visits include review of the kitchen and	09/26/2025

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F0925 SS = F	Continued from page 37 8/4/25 9:20 AM - During the initial kitchen tour, ants were observed crawling on containers in the dry food storage room. Findings confirmed by E5 (DOD). 8/12/25 12:15 PM - Documentation from contracted pest control servicer stated, "...I checked all traps in the kitchen and treated all around for ants..." 8/13/25 3:00 PM - Findings were observed during the exit conference with E1 (NHA), E2 (RDCS), E3 (DON), E4 (ADON), and representatives with the management company, MC1 and MC2.	F0925	Continued from page 37 are overseen by the Maintenance Director and logged in the Pest Control Binder. The Dietary Staff will be re-educated by the Regional Dietary Manager on the policies and procedures for food storage, disposal of expired food, and kitchen cleaning. Dietary Supervisors and designees will be educated on their responsibility to enforce these policies on each shift. The Administrator and Dietary Director will conduct daily rounds of kitchen to audit for adherence to policies and procedures and ensure proper sanitation standards are being met and kitchen is free of pests including ants. Audits will continue daily for 30 days until 30 days of 100% compliance are achieved. After this, audits will decrease to weekly for 60 days until 60 days of weekly audits show 100% compliance. Results of the audits will be submitted to the QAPI Committee for further review and recommendations. Date of compliance: 9/26/2025	