STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pike Creek Nursing & Rehabilitation Center	5651 Limestone Road Wilmington, DE 19808

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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) 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 [NAME] 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. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-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. -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.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 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 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).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 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 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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).

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 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 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.