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	05/19/2026

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 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, interview, record review and review of other facility documentation, it was determined that for two (R29 and R30) out of three residents sampled for quality of care, the facility failed to ensure that R29 and R30 were assessed by a Registered Nurse after it was identified that they had fallen to the floor. The facility also failed to ensure that the post fall documentation was completed, and the physician and responsible parties were notified in a timely manner. Due to the facility's corrective measures completed on 5/11/26, the facility was notified that R29's and R30's incidents were past non-compliance. Findings include:1. R29's clinical record revealed:3/26/26 - R29 was admitted to the facility with diagnoses including, but not limited to, right shoulder fracture and lung cancer.4/4/26 - R29's MDS assessment documented a BIMS score of 15, indicating a fully intact cognitive status. The assessment also documented that R29 required the assistance of one staff member for transfers.5/7/26 3:23 PM - A facility incident report submitted to the Division included, . The resident [R29] told the therapy staff that she sat on the floor this morning and scooted to the call bell and rang and someone helped her up. She stated a nice gentleman, and a lady picked her up.5/19/26 9:30 AM - During a telephone interview, E7 (CNA) stated, I saw her [R29] sitting on the floor near her bed. I held her hand and helped her back to her bed. The Surveyor asked E7 if nurse was informed that the resident was found sitting on the floor. E7 stated, No, I forgot to tell the nurse.5/19/26 10:00 AM - A review of R29's clinical record lacked evidence of a post-fall assessment by a Registered Nurse for possible injuries after she was found sitting on the floor and before being moved by the CNA.2. R30's clinical record revealed:4/29/26 - R30 was admitted to the facility with diagnoses including, but not limited to, Parkinson's disease and acute pain due to trauma.5/6/26 - R30's MDS assessment documented a BIMS score of 13, indicating a mild cognitive impairment, and was dependent on staff for all transfers.5/7/26 12:00 PM - A facility incident report submitted to the Division included, . An anonymous note was received by the HR (Human Resources) Office alleging that [R30] had fallen on 5/5/26 and the fall went unreported. The facility's investigation revealed that the incident had occurred on 5/6/26 at approximately 6:30 AM.5/19/26 12:30 PM - During a telephone interview, E8 (CNA) stated, I was passing by the room, and I saw the resident [R30] on the floor in a kneeling position on the side of his bed. His hands were on the bed like he was trying to get himself back up. I saw his aide [E9 CNA] in the hallway and told her that the resident was on the floor. I then saw the nurse [E10 LPN] and the aide [E9] in the hallway and told them that he was on the floor. They went into his room. The Surveyor asked E8 how she became aware that the fall was not reported. E8 stated, Because no one asked me for a statement about the fall.5/19/26 12:45 PM - During a telephone interview, E9 stated, The nurse [E10] and I went into the room and saw the resident kneeling on the side of the bed. We helped him back into his bed. The Surveyor asked E9 whether a nursing assessment had been completed before R30 was helped back to his bed. E9 stated, No, we just put him back to bed.5/19/26 1:00 PM - The Surveyor left a telephone message for E10 requesting a return call. E10 did not call back while the survey was in progress.5/19/26 1:30 PM - During an interview, E1 (NHA) and E3 (DON) stated that they were aware that R29 and R30's falls were not reported, the post-fall assessments, physician and family notification, and documentation were not being completed, and they immediately began a plan of correction.5/19/26 2:00 PM - The (continued on next page)

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 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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility provided the Surveyor the following information:a. The staff members who did not report the falls received disciplinary action and education on reporting falls.b. Falls for the past 2 weeks were reviewed to ensure that they have the risk management report and required documentation completed.c. A Quality Assurance meeting was held to address physician and responsible party notification, and education started for all staff related to reporting falls, documentation required to include a risk management report at the time of the fall. RN fall documentation, post-fall investigation, and fall risk scoring tool.d. The DON/designee will audit all falls to ensure the required assessments and documentation are completed, and if necessary, reported to the proper State Agency. These audits will be completed daily x 5 days, then weekly x 3 weeks, and then monthly x 2 weeks. The results will be brought to QAPI for review and follow-up as needed.5/19/26 2:15 PM - The Surveyor conducted record review, and staff interviews, and the plan of correction was verified.5/19/26 3:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the Exit Conference.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, record review and review of other facility documentation, it was determined that for one (R2) out of three residents sampled for accidents, it was determined that the facility failed to ensure that R2 received adequate supervision and assistive devices to prevent accidents to the extent possible. Findings include:1/29/24 - A facility document entitled, Falls Management Program, included, A fall is defined as an unintentional change in elevation coming to rest on the ground or onto the next lower surface (e.g. onto a bed, chair or bedside mat.) An episode where a patient would have fallen, if not for staff intervention, is considered a fall.R2's clinical record revealed:11/25/25 - R2 was admitted to the facility with diagnoses including, but not limited to, congestive heart failure and chronic arterial ulcer of the right foot.2/24/26 - R2's quarterly MDS assessment documented a BIMS score of 11, indicating a moderately impaired cognitive status (decisions poor; cues/supervision required). The MDS also documented that R2 was dependent on staff for wheelchair mobility.11/26/26 - R2's fall care plan included, .At risk for falls related to poor balance.4/19/26 11:15 AM - R2's nursing progress note included, . Per CNA assigned to the resident, the resident fell while being helped out of the bathroom back to her room. The resident was sitting in her w/c [wheelchair], and the CNA was behind her. Resident was requested to put her legs up while sitting on her w/c, and all of a sudden, before she could even do it, she fell.5/19/26 9:15 AM - During an interview, R2 stated, I had just finished in the bathroom, and the girl [CNA] was wheeling me back to my room, and I fell forward out of the chair. I am glad I was not hurt. The Surveyor asked R2 whether the foot pedals were on the wheelchair when she was in the wheelchair. R2 stated, No.5/19/26 10:00 AM - During an interview, the Surveyor asked E6 (OT) whether R2 could keep her lower extremities elevated during transportation with the wheelchair. E6 stated, No. [R2] is dependent on wheelchair mobility.5/19/26 11:00 AM - The facility's investigation included, The CNA stated she was going to take the resident back to bed. She requested the resident lift her legs and feet, and the resident fell forward out of the wheelchair.The facility failed to ensure that R2 was free from accidents when she fell while she was transported in a wheelchair without footrests. 5/19/26 3:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the Exit Conference.