

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365676	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Delaware Court Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4 New Market Dr Delaware, OH 43015	
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure fall interventions were in place as ordered. This affected one Resident (#39) out of four Residents (#6, #39, #51, and #58) reviewed for fall incidents and accident prevention. The facility census was 59. Findings Include: Review of the medical record for Resident #39 revealed the resident was admitted to the facility on [DATE]. Diagnoses included late onset Alzheimer's disease, dementia in other diseases, and anxiety disorder amongst other diagnoses. Further review of Resident #39's medical record revealed a Brief Interview for Mental Status (BIMS) score could not be evaluated as the resident was rarely or never understood as of the Minimum Data Set (MDS) 3.0 assessment completed on 04/03/26, though the resident was noted to have severe cognitive impairment. Review of the physician orders revealed Resident #39 had an order for an alarm to be placed in the resident's chair and bed every shift for safety, with a start date of 02/24/26 and an end date of 05/18/26. Additional review of the physician orders revealed continued alarm orders after 05/18/26, including an order for a pressure alarm to be used while in bed along with checking to ensure the correct functioning and placement (start date 05/18/26), and a tab alarm used while up in chair/wheelchair, checking function and placement each shift (start date 05/18/26). Review of the progress notes in Resident #39's medical record revealed a nurse's note, dated 05/16/26 at the time 9:34 PM documented Certified Nursing Assistants (CNAs) came to notify the nurse/author of the note that Resident #39 had fallen from their wheelchair while in the hallway on the evening of 05/16/26 around 8:15 P.M. Further review of this progress note revealed Resident #39 was found lying on their left side on the floor, with bleeding above their left eye and at their left hand. Additional review of this progress note revealed staff were instructed not to move the resident, neurological checks were initiated, an Emergency Medical Services (EMS) squad was promptly called to send the resident to the hospital for further assessment and treatment, and the EMS squad arrived 8:22 P.M. on 05/16/26. Further review of progress notes contained in Resident #39's medical record revealed another nurse's note, dated 05/16/26 at the time 11:49 PM revealed Resident #39 returned to the facility from the hospital at 10:49 P.M. on 05/16/26. Review of this progress note revealed that while at the hospital, computed tomography (CT) scans of the cervical spine (spine area near the neck) and the head or brain, both without contrast were completed for Resident #39 with no reported findings on discharge paperwork or from the EMS squad upon the resident's return to the facility. Further review of this progress note revealed Resident #39 returned to the facility with steri-strips (adhesive strips used to hold skin together for healing in cases where sutures/stitches are often not needed) applied at their left forehead and left hand. The resident was noted to have been diagnosed with skin tears at both the left forehead and left wrist while at the hospital after their fall on the evening of 05/16/26. Review of an additional nurse's note found in Resident #39's medical record, dated 05/16/26 at the time 11:50 PM revealed fall intervention education to staff was completed to ensure Resident #39's bed/chair alarm was in place and powered on when assisting the resident to bed and assisting the resident into their wheelchair, because the chair alarm was not found in the resident's wheelchair at the time they fell, although there were active orders for it at the time of 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fall. Further review of this progress note revealed when the resident fell out of their chair, it was noted that she did not have chair alarm in her w/c. Interview on 06/04/26 at 4:42 P.M., with Registered Nurse (RN) #93 revealed they were working during the shift when Resident #39 fell on [DATE] and verified no chair alarm was found in Resident #39's wheelchair at the time the resident was found on the floor and noted to have fallen out of their wheelchair around 8:15 P.M. on that evening. Further interview with RN #93 at this time revealed they believed the wheelchair alarm would likely not have stopped Resident #39 from trying to get out of their wheelchair on their own, though had the alarm been placed as it should have been, perhaps the sound of the alarm would have notified staff who may have been able to prevent the fall. Interview on 06/04/26 at 6:00 P.M., with the Interim Director of Nursing (DON) verified their knowledge of the events that occurred in relation to Resident #39's fall on 05/16/26 was consistent with the documentation available in the medical record, and that a soft file of an investigation had been completed for the fall. Further interview with the DON at this time revealed a care conference was held with the Interdisciplinary Team (IDT) and Resident #39's family shortly after the resident returned to the facility from the hospital to review fall interventions in place for Resident #39 and discuss options to prevent future falls. This deficiency represents non-compliance investigated under Complaint Number 3013574.		