STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365676	A. Building B. Wing	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Court Health Care Center	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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, resident and staff interview, the facility failed to address resident concerns brought up at the resident council meetings. This affected four Residents (#23, #27, #30, and #44). Facility census was 59. Findings Include:1. Review of the medical record for Resident #23 revealed an admission date of 09/09/25. Diagnoses included atrial fibrillation, pulmonary disease, dysphagia and fracture of the right foot. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition. 2. Review of the medical record for Resident #27 revealed an admission date of 10/02/24. Diagnoses included dementia, pulmonary disease, dysphagia and heart disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 10 indicating impaired cognition. 3. Review of the medical record for Resident #30 revealed an admission date of 01/06/25. Diagnoses included memory deficit, chronic kidney disease and hypertension. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of eight indicating impaired cognition. 4. Review of the medical record for Resident #44 revealed an admission date of 04/05/24. Diagnoses included vascular disease, legal blindness, and dysphagia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition. Review of the resident council meeting minutes from 01/27/25 through 01/28/26 revealed the residents voiced concerns about wanting a larger variety of snacks at the 02/22/25, 04/22/25, 05/23/25, 07/23/25 and 12/17/25 meetings. The residents also voiced concerns about food being delivered cold at the 01/27/25, 05/23/25, 07/23/25, 11/18/25, 12/17/25 and 01/28/26 meetings. Review of the facility provided concern forms revealed the following responses to the resident council concerns. Review of concern forms from 01/27/25 meeting revealed no mention of food temperature related concerns. Review of the concern form dated 02/27/25 revealed snacks are only ordered for the week on the nightly and would send fruit out if it was left over. Review of the concern form dated 04/24/25 revealed the variety of snack was addressed with We buy what is on the menu and will have different fruit in the next cycle. Review of the concern form dated 05/30/25 revealed facility was doing meal tray temperatures when the food got to the floor, and did not address the lack of variety of snacks. Review of the concern form dated 07/26/25 revealed the concern form did not address the lack of variety of snacks or the food temperatures being cold. Interviews on 09/30/25 at 10:50 A.M. with Residents # 23, #27, #30 and #44 who reported concerns with the variety of snacks and stated they have asked for more variety and options and facility does not follow up. They reported facility gives excuses why they need peanut butter sandwiches but that should not prevent them from offering additional options. Residents stated they have asked for variety of chips and fruit and have never been offered choices or a list of items that can be purchased by the supplier. The residents also reported concerns of the food being cold on a consistent basis. They confirmed food has been served cold in resident rooms as well as in the dining room. Review of the concern form dated 12/18/25 revealed concerns of cold food at dinnertime and residents were requesting more variety than pudding, jello, and peanut butter sandwiches. The plan included turning up the steam table to full temperature to see if this is 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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	problem. It also stated facility had certain snacks on certain days and peanut butter sandwiches had to be provided every day for diabetic residents. Review of the resident council meeting minutes dated 01/28/26 revealed resident concerns of food arriving to their rooms cold. Interview on 01/29/26 at 4:22 P.M. with the Administrator revealed facility completed concern forms for concerns brought up in resident council meetings. Interview on 02/09/26 at 11:38 A.M. with Activity Director (AD) #108 revealed resident concerns get documented in the resident council minutes and revealed she then write up concern forms and provides them the appropriate department head to be reviewed and completed and should be returned to the Administrator for review and then finally returned to her for documentation purposes. AD #108 confirmed residents had consistent concerns related to the variety of snacks offered to the residents. She reported residents had memory care issues and may not remember the information they are reporting as a reason why this was consistently reported. She also denied knowledge of facility offering the variety residents had requested and reported the Kitchen Manager frequently came to the resident council meetings to hear concerns first-hand. AD #108 also acknowledged resident complaints of food temperature (cold food) were reported majority of months reviewed. She denied any knowledge of what facility was doing to make improvements and also denied any knowledge of test trays being completed and results reported to residents during the resident council meetings. AD #108 confirmed resident concerns should be taken seriously and addressed in a timely manner. AD #108 acknowledged there was a concern that the same issues were reported over and over again without consistent improvement. Review of the facility policy titled Resident Council Meetings undated, revealed residents shall have a structured forum to voice concerns. Administration shall respond in writing to concerns and recommendations raised by the resident council.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, interviews and facility policy review, the facility failed to ensure residents resided in a safe, clean and comfortable environment. This affected six residents (#3, #9, #27, #33, #41 and #50) of seven (#21) reviewed for environmental concerns. The census was 59Findings Include:A facility tour conducted on 01/28/26 at 8:15 A.M. revealed all resident rooms, and the resident private dining room had a Packaged Terminal Air Conditioner (PTAC) unit (a self-contained heating and cooling unit in which offer individual room control) . The temperature outside on this day was cold with daily highs in the mid to low teens and lows near or below zero Fahrenheit.Observation on 01/28/26 at 8:30 A.M. of the Resident Private Dining Room revealed the PTAC unit was installed below the room window. The unit was secured to the wall, however, on the right side of the unit there was a 1/4 inch opening between the PTAC unit and the wall where the unit did not span the opening leaving a gap opened to the outside which allowed cold air to come into the room.Observation conducted on 01/28/26 at 1:16 P.M. Resident 3's room revealed the PTAC unit was installed below the room window. The unit was secured to the wall, however, on the right side of the unit there was a 1/4 inch opening between the PTAC unit and the wall where the unit did not span the opening leaving a gap opened to the outside which allowed cold air to come into the room. This was verified by Licensed Practical Nurse (LPN) #175. Observation conducted on 01/28/26 at 1:20 P.M. of Resident # 33 room with Certified Nursing Assistant (CNA) #131 room revealed the PTAC unit was installed below the room window. he unit was secured to the wall, however, on the right side of the unit there was a 1/4 inch opening between the PTAC unit and the wall where the unit did not span the opening leaving a gap opened to the outside which allowed cold air to come into the room. CNA #131 confirmed the gap between the PTAC and the wall and the cold air coming into the room at the time of the observation. Observation conducted on 01/28/26 at 1:26 P.M. of Resident # 9 and Resident # 41 room revealed the PTAC unit was located under the window and not sealed around the entire unit . This was verified with Housekeeping Staff Member # 180 and confirmed that cold air was coming through the gap from the outside. Additionally on the right side of the unit from the top of the unit to the base board touching the floor , the wallpaper was peeling away from the wall (approximately 10 inches wide) exposing a dark substance all over the wall and the back of the wallpaper. Under the PTAC unit there was a white bath towel rolled up. Housekeeper #180 verified the black substance on the wall and wallpaper and the rolled up bath towel under the unit. Resident #9 stated during the observation that she can feel the cold air and explained the towel under the unit is used to soak up water that comes in from the outside elements. Resident #9 stated she had reported the problem several times to the administration with no results. Observation conducted on 01/28/26 at 1:30 P.M. of Resident # 27 room with Housekeeper #180 room revealed the PTAC unit was installed below the room window. The unit was secured to the wall, however, on the right side of the unit there was a 1/4 inch opening between the PTAC unit and the wall where the unit did not span the opening leaving a gap opened to the outside which allowed cold air to come into the room. The wood exposed to the outside appeared to be wet and black like it was damaged. Housekeeper #180 verified the findings at the time of the observation. Interview on 01/28/26 at 1:35 P.M. with the Maintenance Supervisor #100 revealed he was to go around the rooms and check if the PTAC units in each room allowed cold air into the facility and if so, he was to seal the areas with silicone. To his knowledge he was not aware of cold air coming through areas around the PTAC units.Interview on 01/29/26 at 8:47 A.M. With Resident #9 confirmed cold air is still coming into the room and the Maintenance Supervisor # 100 sealed the wallpaper to the wall. Resident #9 stated she was unhappy with the solution and was not asked if she wanted to change rooms to allow the PTAC unit to be serviced. Interview with the Administrator on 02/09/26 at 9:15 A.M. confirmed there were no Maintenance Work Order Request Forms for the PTAC units and for wallpaper coming away from the walls.Interview on 1/28/26 at 9:49 A.M. with the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Maintenance Supervisor #100 confirmed he did check all the PTAC units in the resident rooms and sealed some of them. When asked what he did about the exposed black wall in Resident # 9 and Resident #42 room , he sealed the loose wallpaper to the wall . However, he did not prevent the cold air from coming into the room because the unit must be removed from the wall and from outside and installed correctly to prevent weather elements from coming into the room. Maintenance Supervisor confirmed the problem with the PTAC unit with Resident #9 and Residents #42 room was reported to him in the fall of 2025.Observation conducted on 02/09/26 at 1:55 P.M. of Resident # 50 room revealed PTAC unit was installed below the room window. The unit was secured to the wall, however, on the right side of the unit there was a 1/4 inch opening between the PTAC unit and the wall where the unit did not span the opening leaving a gap opened to the outside which allowed cold air to come into the room. The wallpaper on the right side of unit close to the floor baseboard is starting to peel away from the wall. This was verified by CNA #163. During the observation Resident # 50 stated, that is probably why I have bugs in my room.Review of the facility's , Maintenance Work order Request Form Completion Policy and Procedure not dated, revealed it is the policy of the facility to ensure a safe , functional, and comfortable environment for residents, staff and visitors through a standardized and efficient process for requesting, prioritizing, and completing maintenance work. All maintenance requests will be documented using the Maintenance Work Order Request Form. To ensure proper tracking, accountability, and timely resolution of issues.This deficiency represents non-compliance investigated under Complaint Number 2661246.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview and policy review the facility failed to ensure proper indication of use for medication, and failed to ensure duplicate medication had maximum dosage for use indicated, this affected one resident (#36) of five reviewed for unnecessary medications. The facility also failed to ensure pain medications were ordered with parameters and administered appropriately. This affected two Residents (#10 and #36) of two reviewed for pain management. The census was 59. Findings Include: 1. Review of the medical record for Resident #36 revealed an admission date of 02/14/25. Diagnoses included dementia, cerebral infarct, fractured tibia, malnutrition, vascular disease and osteoporosis. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 03 indicating impaired cognition. Review of physician orders dated 02/14/25 revealed an order for Acetaminophen (antipyretic/analgesic) tablet 325 milligram (mg) with instructions to give two tablets every four hours as needed for fever, an order for Acetaminophen tablet 325 mg with instructions to give two tablets every four hours as needed for pain. The physician orders did not include a maximum dosage for the Acetaminophen or a statement to not exceed a specific amount in 24 hours. The orders for the Acetaminophen 325 mg two tablets every four hours as needed for pain did not have parameters for use included. Review of physician orders dated 02/15/25 revealed an order for Ascorbic Acid (vitamin) tablet 500 mg with instructions to give one tablet once daily for sepsis, and Cholecalciferol (vitamin) Tablet 1000 unit with instructions to give one tablet once daily for sepsis. Review of physician orders dated 02/17/25 revealed there was an order for Norco (opioid) oral tablet 5/325 mg with instructions to give one tablet by mouth every eight hours as needed for pain. The orders for the Norco 5/325 mg oral tablet every four hours as needed for pain did not have parameters for use included. Review of the Medication Administration Report (MAR) dated 01/2026 revealed Acetaminophen tablets were given on 01/29/26 for a pain level of six and Norco tablet were given on 01/04/26 for pain level four, 01/06/26 for pain level of five, 01/07/26 for pain level of four, and 01/09/26 for pain level of four. Interview on 01/29/26 at 2:35 P.M. with Regional Nurse #178 confirmed two separate orders for pain medication (Acetaminophen and Norco). The regional nurse confirmed the order should have parameters so staff know when to administer which medication. Regional Nurse #178 confirmed Resident #36 had two separate orders for Acetaminophen one for fever reduction and the other for pain in their plan of care. The regional nurse confirmed the orders did not specify any parameters or daily safe maximum dosage of the medication. The regional nurse stated the orders would typically include a statement of a maximum amount, or that the resident should not exceed a certain dose. Regional Nurse #178 also confirmed sepsis was not an appropriate diagnosis for vitamins such as Ascorbic Acid and Cholecalcferol tablets. She confirmed the facility should ensure an appropriate diagnosis was documented for each medication used by the resident. 2. Review of the medical record for Resident #10 revealed an admission date of 04/17/23. Diagnoses included hemiplegia and hemiparesis, chronic obstructive pulmonary disease, diabetes, cerebral infarction, paralytic syndrome and dysphagia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition. Review of physician orders dated 09/19/24 revealed an order for Acetaminophen tablet 500 mg with instructions to give two tablets every eight hours as needed for pain. The orders for the Acetaminophen 500 mg two tablets every eight hours as needed for pain did not have parameters for use included. Review of physician orders dated 04/01/25 revealed an order for Oxycodone HCL (opioid) oral tablet 5 mg with instructions to give one tablet by mouth every eight hours as needed for pain. The orders for the Oxycodone 5 mg one every eight hours as needed for pain did not have parameters for use included. Review of the Medication Administration Report (MAR) dated 01/2026 revealed Acetaminophen tablets were given once on 01/01/26 for a pain level of six, once on 01/11/26 for a pain level of three, twice on (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/13/26 for pain levels of six and four, once on 01/14/26 for pain level of eight, once on 01/16/26 for a pain level of eight, and once on 01/30/26 for a pain level of seven. The Oxycodone tablets were given twice on 01/01/26 for pain levels seven and six, twice on 01/02/26 for pain levels of five and four, twice on 01/03/26 for pain levels of four and four, once on 01/04/26 for pain level of four, twice on 01/06/26 for pain level of five and seven, once on 01/07/26 for a pain level of four, once on 01/08/26 for pain levels of seven, once on 01/09/26 for a pain scale of six once on 01/10/26 for pain levels of three, once on 01/11/26 for a pain scale of four and once on 01/12/26 for a pain level of four, twice on 01/13/26 for pain level of five and five, once on 01/15/26 for a pain level of eight, once on 01/16/26 for pain levels of four, once on 01/17/26 for a pain scale of four, once on 01/19/26 for pain level of one, once on 01/20/26 for a pain scale of seven, twice on 01/21/26 for pain levels of five and four, twice on 01/22/26 for pain levels of four and seven, once on 01/23/26 for a pain level of four, once on 01/24/26 for a pain level of four, once on 01/25/26 for pain levels of three, twice on 01/26/26 for pain scales of six and four, twice on 01/27/26 for pain levels of seven and seven, twice on 01/28/26 for pain scales of six and four, once on 01/29/26 for a pain level of seven, once on 01/30/26 for a pain level of four and once on 01/31/26 for a pain level of four. Review of the Medication Administration Report (MAR) dated 02/2026 revealed an Acetaminophen tablets was given on 02/08/26 for a pain level of five and Oxycodone tablets were given once on 02/01/26 for pain level four, twice on 02/02/26 for pain levels of six and four, twice on 02/03/26 for pain levels of six and eight, once on 02/04/26 for pain level of six, once on 02/05/26 for pain level of seven, once on 02/06/26 for a pain level of five, twice on 02/07/26 for pain levels of four and three, and twice on 02/08/26 for pain levels of five and four. Interviews on 02/09/25 from 11:00 A.M. to 1:00 P.M. with Regional Nurse #178 confirmed no pain medication parameters were put in place and also confirmed high pain scores of seven and eight were given Acetaminophen and scores of zero and three were given for Oxycodone. Review of the facility policy titled Pain Management undated, revealed the facility shall provide adequate management of pain to ensure residents attain or maintain the highest practicable well-being. When prescribing analgesics, the medical conditional shall be evaluated and determined the most appropriate therapy for pain. Chronic pain relief should begin with a low dose and titrate carefully until comfort was obtained.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and record review, facility failed to ensure food was served and at a safe and palatable temperature. This had the potential to affect all facility residents except Resident #2. Facility census was 59. Findings include:Observation and interview on 09/30/25 at 12:25 P.M. with Dietary Staff (DS) #183 revealed food was being served to residents in the dining room and about half of the dining room had been served lunch. Dietary staff #183 was asked about food temperatures and DS #183 stated they took cooking temperatures but not holding temperatures. Temperatures were then obtained of food items on the hold steam table and found the green beans were 184 degrees Fahrenheit (F), the mashed potatoes were 178 degrees F, the burger patties were 120 degrees F, the salmon patties were 74 degrees F and the potatoes were 146 degrees F. The burger patties and salmon patties were placed back in the oven after surveyor intervention. DS #183 stated if the puree food had not taken so long, the food would not be outside the required temperatures. Interview on 09/30/25 at 12:40 P.M. with Kitchen Manager #141 stated the goal temperature for food held on the steam table was 150 degrees F. Observation and interview on 09/30/25 at 1:08 P.M. of test tray holding temperatures prior to making the test tray plate revealed the salmon patty holding temperature was 119.5 degrees F, the potatoes holding temperature was 106 degrees F, and the hold temperature of the green beans was 139 degrees F. The tray left the kitchen at 1:19 P.M. and was placed on a non-insulated cart and taken to the resident hall and at 1:30 P.M. after all trays were passed out to residents from the cart, the test tray had a temperature check performed and found the salmon patty was 106 degrees F, the potatoes were 96 degrees F and the green beans were 109 degrees F. The food tasted cold and the kitchen manager declined to taste the food and confirmed it would be cold. She confirmed they had plate warmers, but stated this particular hallway did not have a warming cart as the facility only had three insulated carts and only used a metal rack for this hallway. Review of the facility policy titled Holding Food Temperatures and Guidelines undated, revealed all food shall be held on the serving line at proper temperatures to promote optimum palatability, ensure food safety and prevent food [NAME] illness. Facility shall obtain serving line food temperatures at the beginning middle and end of the meal service. The temperature shall be palatable per resident preference and facility shall ensure they use methods to retain temperature of hot food items during meal service including a proper functioning steam table and heated plates. Hot foods should have a holding temperature of 135 or higher. This deficiency represents non-compliance investigated under Complaint Number 2661246.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility failed to ensure puree food was made to the correct consistency. This affected six residents (#7, #21, #25, #28, #42, and #52) who had orders for puree food. Facility census was 59. Findings include:1. Review of the medical record for Resident #7 revealed an admission date of 10/29/21. Diagnoses included cerebral infarction, respiratory failure, protein malnutrition, dysphagia, and parkinsonism. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition. Review of physician orders dated 08/27/25 to 10/18/25 revealed an order for puree texture food. 2. Review of the medical record for Resident #21 revealed an admission date of 01/25/24. Diagnoses included malnutrition, heart disease and osteoporosis. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 00 indicating impaired cognition. Review of physician orders dated 08/27/25 to 10/16/25 revealed an order for puree texture food. 3. Review of the medical record for Resident #25 revealed an admission date of 07/24/25. Diagnoses included hemiplegia and hemiparesis, dysphagia, Alzheimer's disease, and dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of three indicating impaired cognition. Review of physician orders dated 09/17/25 to 01/14/26 revealed an order for puree texture food. 4. Review of the medical record for Resident #28 revealed an admission date of 10/02/24. Diagnoses included Parkinson's disease, malnutrition, heart disease, failure to thrive and dysphagia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of one indicating impaired cognition. Review of physician orders dated 11/18/24 to 01/08/26 revealed an order for puree texture food. 5. Review of the medical record for Resident #42 revealed an admission date of 01/25/24. Diagnoses included Alzheimer's disease, malnutrition, dementia and vascular disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of two indicating impaired cognition. Review of physician orders dated 05/09/25 revealed an order for puree texture food. 6. Review of the medical record for Resident #52 revealed an admission date of 02/28/22. Diagnoses included dementia, malnutrition, pulmonary disease and vascular disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of five indicating impaired cognition. Review of physician orders dated 07/15/24 revealed an order for puree texture food. Observation and interview on 09/30/25 at 11:57 A.M. with Dietary Staff #144 revealed the facility had several residents that received puree diets. He began with three breaded salmon patties and added chicken broth with one spoonful at a time for a total of eight spoonfuls of broth in the roboku mixer. On three occasions Dietary Staff #144 wiped the sides of the roboku mixer with his gloved hand and then scraped the food on the glove on the edge of the mixer. Then with the same hand grabbed a jar of broth to add more liquid to the mixture (unmeasured). Several chunks were visualized on the sides of the mixer that were not fully mixed back in. The puree was completed and taste tested and found to have small chunks of salmon and breading. Dietary staff confirmed the mix had chunks and distinct pieces but stated it was the best they were going to get it. He confirmed they were looking for mashed potato consistency. Review of the facility policy titled Puree Diets dated 2022, revealed this diet was for residents who cannot chew or have difficulty swallowing. The sides of the blender shall be scraped and processed until smooth like pudding. This deficiency represents non-compliance investigated under Complaint Number 2661246.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interviews, and policy review the facility failed to ensure food was stored in a safe and sanitary manner, failed to ensure proper hand hygiene was completed when making puree food, taking food temperatures and during tray line service and failed to ensure the kitchen maintained proper sanitation. This affected all Residents except Resident #2 who did not eat food from the kitchen. Facility census was 59. Findings include1. Observation on 09/30/25 from 08:10 A.M. to 8:25 A.M. revealed a bowl of cookies in envelopes with no date on the bowl or on the individual envelopes. A tray of cookies sitting on the prep table on a cookie sheet that was not covered. Three pre made sandwiches wrapped in foil were left in the fridge and were undated and unlabeled. A large metal bowl with fajita mix was covered with plastic wrap and was not dated. A bag of vanilla wafers was open to air and not sealed. 14 chocolate magic cups were thawed and the container/package stated to keep frozen. Six cups of yogurt were found to be undated. A red bowl was found in the fridge with an unknown substance in it was undated and an open bottle of water was found to be undated. Two cups of pre-poured orange juice, two cups of pre-poured milk and one cup of pre-poured apple juice were also left undated. Interview on 09/30/25 at 8:25 A.M. with Kitchen Manager #141 confirmed food storage findings and revealed items should be covered, labeled and dated. Review of the facility policy titled Dry Storage Areas dated 2023, revealed dry storage areas shall be maintained to keep food safe and free of infestation or contamination. Review of the facility policy titled Food Storage dated 2023, revealed storage areas shall be maintained to keep food safe and free of cross contamination or contamination. All stock shall be rotated using first in and first out method. Food should be dated as it was placed on the shelf. Plastic containers with tight fitting covers or sealed plastic bags must be used for storing opened packages and all containers must have legible and accurate labels and dates. 2. Observation and interview on 09/30/25 at 11:57 A.M. with Dietary staff #144 revealed he was making puree salmon patties. During the blending process Dietary staff #144 blended three salmon patties and broth in the roboku mixer. Dietary staff reached his gloved hand into the mixer and scraped the sides. Then with the same gloved hand, grabbed a jar of broth to add in more liquid and continued to use his same gloved hand to scrape the sides of the blender. He reported staff had been instructed to use their hand to scrape the inside of the blender and were told they were not allowed to use kitchen utensils such as a spatula. The Dietary staff member did not preform any hand hygiene between each time of reaching in the blender and scraping the sides and grabbing other kitchen items (broth) and pressing buttons on the roboku blender. Observation and interview on 09/30/25 at 12:25 P.M. with Dietary staff #183 confirmed he took food temperatures and stuck his fingers in the food (baked beans) then used his fingers to wipe the thermometer then used a sanitizer wipe and without preforming hand hygiene/switching gloves, he placed the thermometer in the salmon patties and repeated the process before placing the thermometer in the potatoes. Dietary staff #183 confirmed he used his gloves to wipe the thermometer which soiled his gloves that were also not changed, then he stuck his fingers in the food items. Observation and interview on 09/30/25 at 12:40 P.M. with Kitchen Manager #141 revealed Dietary staff #144 pulled a roll from the bag and cut in half with a knife then with the same gloves grabbed food on the tray line (salmon patty) with his hands. The Kitchen Manager confirmed staff should have changed gloves and instructed him to change his gloves anytime he touches food. Review of the facility policy titled Hand Washing undated, revealed hands and exposed portions of arms shall be washed in accordance with established standards of practice to prevent cross contamination. Employees shall change gloves as necessary and wash hands after handling soiled equipment and utensils, between handling soiled and clean dishes, and when changing tasks. Review of the facility policy titled Disposable Gloves undated, revealed gloves shall be worn to prevent cross contamination. They shall be worn when handling food to avoid contact with bare hands and shall be used for one task and then discarded when damaged or soiled. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365676	A. Building B. Wing	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Court Health Care Center	4 New Market Dr Delaware, OH 43015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Handwashing should occur prior to putting on gloves and when gloves were changed. 3. Observations on 09/30/25 from 11:57 A.M. to 3:47 P.M. revealed the overhead vents in the kitchen over the food preparation and food service area were dirty and had a thick layer of dust on them. Interview on 09/30/25 at 3:48 P.M. with Kitchen Manager #141 confirmed the confirmed the area was dirty and dust was blowing above food preparation areas. This deficiency represents non-compliance investigated under Complaint Number 2661246.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365676	A. Building B. Wing	02/09/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, and staff interview, this facility failed to ensure an updated Preadmission Screening and Resident Review (PASARR) was completed when a resident was diagnosed with a new mental illness diagnosis. This affected one (Resident #53) of the one resident reviewed for accurate PASARRs. The facility census was 59. Findings include: Review of the medical record for Resident #53 revealed an admission date of 05/29/2020. Diagnoses included dementia, major depressive disorder, generalized anxiety, and delusional disorders. Review of Resident #53's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 indicating an moderately impaired cognition for daily decision-making abilities. Review of the electronically uploaded PASARR dated 03/11/2020 revealed under question. Does this resident have a diagnosis of any mental disorders? This question was noted as no. Interview on 09/30/2025 at 2:13 P.M. with the Director of Nursing (DON) confirmed the PASARR was not updated and should have been with newly added mental illness diagnosis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365676	A. Building B. Wing	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Court Health Care Center	4 New Market Dr Delaware, OH 43015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0868 Level of Harm - Potential for minimal harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and interviews, the facility failed to ensure the Quality Assurance meetings occurred quarterly as required. This had the potential to affect all residents who reside in the nursing facility. The census was 59.Findings include:Review of the Quality Assurance (QA) Meeting Notes for the Facility revealed the committee met on 10/15/24, 1/21/25, 4/15/25, and 7/22/25. There was no quarterly meetings held during the last quarter of 2025. The meeting documentation revealed this was the meeting the medical director participated in at the facility. Review of the facility records revealed the facility held monthly Quality Assurance Performance Improvement (QAPI) meetings, however the medical director did not participate in these meetings. Interview on 02/09/26 at 2:00 P.M. with the Interim Director of Nursing # 179 confirmed the facility does not have QA meeting notes to indicate a meeting was held in the last quarter of 2025. Interview on 02/09/26 at 4:00 P.M. with the Administrator and the Regional Clinical Director # 178, confirmed the Medical Director does not attend the QAPI meetings , he attends the QA meetings only, that are held quarterly.Review of the Facility's QAPI Plan dated 5/23/25 revealed the framework of QAPI included all the department managers, the administrator, the director of nursing, infection control nurse, medical director, consulting pharmacist who will provide QAPI leadership by being on the QAA committee. The QAA committee will meet monthly. The QAA committee will report all activities to the board of directors during their regular scheduled meetings. The administrator will report QAPI activities at the quarterly board of director's meetings. QAPI will be a standing agenda for these meetings. Input will be solicited from the board members on QAPI activities. All current projects and outcomes will be reviewed at the board meetings.