

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER Delmar Gardens West		STREET ADDRESS, CITY, STATE, ZIP CODE 13550 South Outer 40 Road Town and Country, MO 63017	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>46970</p> <p>Based on interview and record review, the facility failed to provide services per acceptable standards of practice and per the resident's plan of care for one of three sampled residents (Residents #1) when staff failed to obtain daily weights and send them to the resident's cardiologist per the physician's order. The census was 180.</p> <p>Review of the facility's Physician Orders, Following policy, dated 6/29/21, showed:</p> <p>-Purpose: It is the policy of the community to ensure that all Licensed Professional Nurses (Registered Nurse (RN)/Licensed Practical Nurse (LPN)) and other Healthcare Professionals, follow Physician Orders in accordance to State, Federal regulations and their respective practice acts;</p> <p>-Procedure included:</p> <p>-All physician orders will be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record;</p> <p>-All physician or other healthcare professional's verbal, telephone or written orders will be immediately entered into the electronic health record (EHR) by the nurse obtaining the order.</p> <p>Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/18/24, showed:</p> <p>-No cognitive impairment;</p> <p>-Diagnoses included: stroke, congestive heart failure (CHF, a chronic condition in which the heart doesn't pump blood as well as it should. When this happens, blood often backs up and fluid can build up in the lungs), high blood pressure and hemiplegia (weakness or an inability to move on one side of the body).</p> <p>Review of the resident's care plan, last reviewed on 8/24/24, and in use during the survey, showed:</p> <p>-Problem: Resident receives daily diuretic therapy (any substance that promotes diuresis, the increased production of urine) related to diagnosis of CHF;</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Goal: Resident will not exhibit signs/symptoms of hypokalemia (low potassium)/dehydration and will be monitored on an ongoing basis;</p> <p>-Interventions included obtain/record weight as ordered.</p> <p>Review of the physician order sheet (POS) , showed an order, dated 8/24/24,for daily weights. Call physician group if weight is up more than three pounds in one day or five pounds in a week.</p> <p>Review of the resident's medical record, showed a letter from the resident's cardiologist to the facility, dated 9/11/24. The letter included: Resident's cardiologist is requesting resident's daily weights to be sent to our office on a weekly basis starting on 9/11/24. Fax number provided.</p> <p>Review of the resident's medical record, showed:</p> <p>-A progress note, dated 9/12/24: New order entered to fax daily weights to resident's cardiologist on a weekly basis. This nurse entered order into EHR for every Monday;</p> <p>-A progress note, dated 9/12/24: This nurse faxed daily weights from 9/1/24 through 9/11/24 to resident's cardiologist;</p> <p>-No documentation staff faxed the resident's weight on the following two Mondays, 9/16 and 9/23/24;</p> <p>-A progress note, dated 9/26/24: Around 12:45 P.M. spoke with representative from resident's cardiologist's office. Informed weights for 9/1 through 9/11/24 were received and weights for 9/12 until now needed to be re-faxed, along with CHF form. Form completed and faxed as requested.</p> <p>Review of the POS, showed an order dated 9/27/24, daily weights to physician's office on a weekly basis starting on 9/11/24. Once a day on Mondays.</p> <p>Review of the resident's medical record, showed:</p> <p>-No documentation staff faxed the resident's weight on the following Monday, 9/30/24;</p> <p>-A progress note, dated 10/7/24: Weekly weights faxed to resident's cardiologist.</p> <p>During an interview on 10/9/24 at 12:21 P.M., LPN A said physician orders should be followed. Any nurse could have faxed the resident's weights to his/her cardiologist. He/She said the resident's family member was there last night asking about the weights. Yesterday, LPN A reviewed the resident's weights through 10/7/24 and faxed them to the cardiologist. LPN A said the nurse assigned to the resident on Mondays was responsible to fax the weekly weights to the cardiologist. LPN A said new orders pop up on the EHR screen to sign off on and when there was something to complete for the order.</p> <p>During an interview on 10/9/24 at 12:39 P.M., LPN D said physician orders should be followed and care plans should be followed as best as possible.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/9/24 at 2:30 P.M., the Director of Nursing (DON) said nurses knew when there were new orders through shift report and the new orders would pop up on their screen for them to sign off on. She said existing orders would pop up too on the nurse's screen if the order required the nurse to do something. They communicated the resident's weights over the phone with the cardiologist's office. She expected nurses to fax the weights every Monday between 7 A.M. and 3 P.M., as the physician order specified. The nurse responsible for faxing the resident's weights was the nurse assigned to the resident on that shift. The DON said nursing staff spoke to the cardiologist and the cardiologist's office said they received all the weights. She couldn't say what the impact of not receiving the weights would be because all residents were different.</p> <p>MO00242708</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>46970</p> <p>Based on observation, interview and record review, the facility failed to ensure the residents' environment remained as free of accident hazards as possible and each resident received adequate supervision and assistive devices to prevent accidents by failing to follow their transfer policy when Certified Nurse Aide (CNA) B, without assistance, attempted to transfer a resident using a Hoyer lift (mechanical lift) (Resident #1). The attempted transfer resulted in the resident sliding off of the lift and hitting the floor. The resident was sent to the hospital for evaluation. The census was 180.</p> <p>Review of the facility's Transfer and Lift policy, reviewed 5/2021, showed:</p> <p>-Purpose: To provide communication to staff about resident transfer abilities and to assure we take all precautions necessary to maintain the safety of our residents including acknowledgement that this facility has adopted a NO LIFT policy (approach that aims to reduce or eliminate staff from the manual lifting of residents) by for residents requiring a mechanical means of transfer;</p> <p>-Upon admission each resident will be assessed by the inter-disciplinary team on the capability of how the resident transfers; this will be re-assessed with changes in condition and at the quarterly care plan;</p> <p>-The resident's transfer ability will be indicated in the resident's orders and included on the resident profile and care plan;</p> <p>-When using a mechanical lift to transfer residents, two employees are required to assist in the transfer, without exception.</p> <p>Review of Resident #1's medical record, showed a physician order, dated 6/22/24, for: Transfer status x 2 Hoyer lift.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/18/24, showed:</p> <p>-No cognitive impairment;</p> <p>-Chair/bed-to-chair transfer, Ability to transfer to and from a bed to a chair (wheelchair): Dependent, staff does all of the effort. Resident does none of the effort;</p> <p>-Diagnoses included: stroke, congestive heart failure (CHF), high blood pressure and hemiplegia (weakness or an inability to move on one side of the body).</p> <p>Review of the resident's care plan, reviewed on 8/24/24 and in use during the survey, showed:</p> <p>-Problem: Resident experiences a deficit in mobility/Activities of Daily Living (ADLs, self-care) function related to hemiplegia, incontinence and the need for assistance with ADL care;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Goal: Resident will maintain current level of mobility;</p> <p>-Approaches included: Provide assistance for transferring. Uses the Hoyer lift with two person assist.</p> <p>Review of the resident's progress notes, showed on 10/9/24 at 9:38 A.M. Licensed Practical Nurse (LPN) A wrote: CNA called for nurse to come to resident's room due to him/her falling from the Hoyer lift during transfer to chair. Resident was on the floor in between the lift and bed, moaning and calling for help. Upon assessment, resident was complaining of neck and back pain with hip and knee pain. Primary doctor and family member notified. Family member requested resident be sent to the hospital for further evaluation. Ambulance transferred resident to the hospital at 9:40 A.M.</p> <p>During an interview on 10/9/24 at 12:21 P.M., LPN A said the resident had been taken to the hospital. This morning, CNA B went to weigh the resident alone. When he/she moved the resident away from the bed in the Hoyer lift, the resident slipped and fell underneath the lift. LPN A said it always took two people to operate the lift. He/She said all CNA B had to do was ask someone to help him/her because there was more than enough staff on the floor. LPN A would have helped if CNA B would have asked. He/She said CNA B was suspended after the incident. LPN A said the expectation for CNA B was for him/her to ask for help from a peer or the nurse when transferring the resident or any other resident who needed a mechanical lift.</p> <p>During an interview on 10/9/24 at 2:07 P.M., Certified Medication Technician (CMT) H said he/she knew the resident and had helped with transferring the resident in the past. CMT H said the resident was a Hoyer lift transfer and it took two people to work the lift always, no exception. He/She said there would never be a time when only one staff transferred a resident with a mechanical lift. Everyone knew that. He/She knew what type of transfer the resident was by a sign on his/her door, shift report, and by looking in the resident's chart. CMT H said he/she never transferred the resident or any other resident using a mechanical lift alone. He/She said CNA B did not ask him/her for help to transfer the resident.</p> <p>During an interview on 10/9/24 at 2:13 P.M., CNA I said he/she knew the resident and his/her transfer information was posted on the wall in the resident's room. He/She said the resident was a Hoyer lift transfer and he/she would know because a lift pad would be in the resident's chair. He/She said it took two people to work the Hoyer lift and there was never a time when only one person should use it to transfer a resident. He/She never transferred the resident or any other resident with a mechanical lift alone. CNA I had been educated on mechanical lifts.</p> <p>During an interview on 10/9/24 at 12:48 P.M., CNA E said it always took two people to operate a mechanical lift. He/She said one person should not use the lift to transfer a resident.</p> <p>During an interview on 10/9/24 at 2:30 P.M., the Director of Nursing (DON) said what happened to the resident today was bad. She helped the charge nurse with the assessment and there didn't appear to be any apparent injuries. She spoke with the hospital, and they told her the resident had no trauma or acute injury. The hospital was looking to discharge the resident back to the facility today. She expected nursing staff to follow the physician's orders. She expected CNA B to ask for help with transferring the resident using a Hoyer lift. She said they provided comprehensive education and reminded staff what the transfer policy was. She expected CNA B and all other staff to follow the transfer policy.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO00242708		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>46970</p> <p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to prevent roaches and gnats in the kitchen, where residents' food was prepared and served. The census was 181.</p> <p>Review of the facility's Pest Control Policy, revised 08/2024, showed:</p> <ul style="list-style-type: none"> -Purpose: To ensure that the facility is free to exposure to pests to include, but not limited to insects, cockroaches, rats, mice, bed bugs, etc; -Procedure: <ul style="list-style-type: none"> -The Director of Environmental Services is the designated coordinator for this facility. This person acts as a liaison between the building occupants and the pest management provider; -Regular inspections will be performed by both the Director of Environment Service/designee and the contracted pest management professional. They will note situations that are conducive to pest populations and recommend repairs, sealing of pest entry points, clutter reduction, improved sanitation, and monitoring procedures; -Repairs will be performed as needed to prevent pest access to buildings or to hiding spaces in walls and equipment. Water leaks will be repaired, and standing water will be eliminated whenever possible; -Proper sanitation will be maintained, and clutter reduced to prevent food and harborage for pests; -Proactive/preventative measures for roaches and other pest: The Environmental and Dining Services staff will regularly inspect and perform and/or request preventative maintenance to ensure areas are clean, dry and pest free; -Wet places: Water is the main draw for any pest, so inspect sinks (including under the lip), dishwashers, pipes, cooler and refrigerator doors, ice machine lids and other areas of water pooling and condensation. Include drains and wet floor mats; -Areas where food debris accumulates: Organic matter collects just about anywhere in a commercial kitchen. Look in the obvious areas - where food is stored, prepared, and served, and where trash is discarded - but also in less conspicuous places, i.e. under equipment; -Storage rooms: Remove all cardboard boxes and other clutter provide harborage for roaches, rodents, and ants; -Heat sources: Inspect all equipment that generates heat, pests will gravitate toward it; -Cracks and holes: Look for any structural weaknesses that might offer pests access to the kitchen. Also check for cracks in the floor tile or worn-away grout; <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Drains and garbage disposal: Roaches are nocturnal, so it is important to block drains at night after pouring Consume Chemical (enzyme that removes food source) down each kitchen drain and garbage disposal (after ensuring disposal is clean and free of food/garbage). Run hot water down sink for a couple minutes prior to pouring Consume down disposal;</p> <p>-If a roach/pest infestation is found in kitchen or service area, proceed with the Night Kitchen Cleaning - Roach/Pest Control check list and immediately call provider.</p> <p>Review of the facility's Kitchen/Service Area/Dry Storage and Dish Room Night Cleaning/Checks - Roach/Pest Control form, showed:</p> <p>-Leave floor fans blowing at top speed in infested area(s);</p> <p>-Ensure no leaks or water sitting in areas;</p> <p>-Ensure all food is completely covered--NO FOOD SHOULD BE LEFT OUT AT NIGHT;</p> <p>-Ensure no open cracks/crevices in walls/floors;</p> <p>-Ensure that no produce boxes, paper bags or cardboard are left in area;</p> <p>-Ensure no dirty dishes are left on dish machine;</p> <p>-Cover all floor and sink drains with stopper and/or rubber mats every night.</p> <p>Review of the facility's Pest Control vendor binder, showed:</p> <p>Areas of concern:</p> <p>-9/29/23: Gnats entire dietary kitchen, office, dish room and janitor area;</p> <p>-10/28/23: Kitchen and doors to kitchen, roaches;</p> <p>-5/20/24: Human Resource/Public Relations office - roaches;</p> <p>-5/21/24: 500 Serving and hot cart - roaches;</p> <p>-8/19/24: Roaches in Recreation office;</p> <p>-The pest control binder concerns were written randomly, were not in chronological order, and did not include the concern for all entries.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 8/21/24 at 10:14 A.M., the Maintenance Director said he had gone around the facility to caulk cracks and holes, anywhere there were hiding spots. He measured all the drains and was in the process of getting covers for the drains. He thought keeping food put away and boxes off the floor would help because the boxes were just an extra place for the roaches to hide. He said the night staff in the kitchen was supposed to put baking soda and vinegar down the drains after dinner. He was Floor Technician D's supervisor, but he didn't know if he/she had sprayed or treated the kitchen in the evening with the chemical.</p> <p>Observation of the facility's main kitchen on 8/20/24 between 10:49 A.M. and 11:55 A.M., showed:</p> <ul style="list-style-type: none"> -Bait traps filled with brown cockroaches; -Cockroaches crawled on multiple walls and on the floor in the kitchen; -There were dead cockroaches in the corners of the kitchen floor; -There was a dead cockroach on a prep table near two boxes of gloves; -Multiple cockroaches crawled on the silver platform where dishes were placed for washing after meal service; -Some cockroaches were dead on the platform in puddles of water; -There were three large white trash bags tied up on the floor near a large trash can in the kitchen; -There was one black fan in the kitchen near a door and was not running. <p>During an interview on 8/20/24 at 10:49 A.M., the Dietitian said the Kitchen Manager was not in today. She said the pest control company came out two times a week. The pest control company left Maintenance some of the chemical used to treat the roaches in the kitchen. The Dietitian said staff sprayed the kitchen last night and thought that was why the roaches were so active today.</p> <p>During an interview on 8/20/24 at 11:15 A.M., a Dietary Aide A said the facility had a lot of roaches and gnats. He/She was told the facility was sprayed last week. He/She had seen the pest control person spray and take away old traps. He/She didn't know when the last time the roach bait traps had been replaced. He/She had seen roaches crawl on resident's plates, but he/she did not serve those plates to residents.</p> <p>Observation on 8/20/24 at 11:15 A.M., showed brown boxes in the walk-in cooler and one large brown box on the floor near a trash can in the kitchen.</p> <p>During an interview on 8/20/24 at 11:55 A.M., Dietary Aide C said bugs and roaches came out from time to time. He/She said a company sprayed every other week and Maintenance had sprayed before too. He/She was off yesterday but thought the last time the facility had been sprayed was four days ago.</p> <p>Observation on 8/20/24 at 11:55 A.M., showed boxes and other items on the floor and up against the wall in the office located in the kitchen area.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 8/21/24 at 10:28 A.M., Resident #3 said he/she had seen roaches in his/her room before but not many. He/She saw roaches on the dining room floor yesterday, but not in his/her food.</p> <p>During an interview on 8/21/24 at 2:17 P.M., Resident #2 said he/she had seen roaches in his/her room and the dining room. He/She said the facility tried to spray when they were told about the roaches. He/She saw roaches crawling on his/her friend's chair in the dining room at lunch today. Resident #2 said he/she had friends living in the facility, whose rooms were infested with roaches. He/She said the residents were moved to a different room and all their clothing was thrown away because of the roaches. He/She said the facility tried to blame the roaches on the residents, but they were clean people. He/She didn't think they were the reason for the roaches in their room.</p> <p>During an interview on 8/20/24 at 12:08 P.M., the Administrator said the pest control company came out last night, so he stayed late. Two guys came out last night and set traps and sprayed an aerosol and liquid spray. The Administrator said he didn't know if the pest control company changed the bait traps every time they came, but they sprayed the kitchen every two weeks. The pest control company left the facility some of the spray concentrate and a Maintenance Technician sprayed the kitchen with it a couple times a week. He said staff mopped the kitchen everyday but the owner of the pest company, who was there last night, said the pest control company told him not to mop the floors for at least twelve hours. The Administrator said before the owner told him that, staff mopped the floor after each meal. He said he had help to power spray the kitchen floor and found he was standing in water. The water wasn't going down the drain. He thinks the facility had the roaches on the run and were in pretty good shape. The Administrator said the pest control company didn't give him any written recommendations but said they were supposed to keep the standing water off the floor.</p> <p>During an interview on 8/20/24 at 1:51 P.M., a Pest Control Company Representative said on 8/19/24, the owner of the pest control company told him/her the roaches were from produce boxes and deliveries being brought into the facility. He/She said that's usually where the problem started. The Pest Control Company Representative said the owner also said the facility's cleaning needed to be stepped up and getting the boxes out of the facility would really help. He/She said getting the water off the floor would really help. When water was on the floor and the chemical was sprayed, it laid on top of the water and was washed away when the water was cleaned up or went down the drain. He/She said water rendered the chemical ineffective. He/She said keeping the floor dry and clean was all that was needed to be done. He/She didn't know if the problem was improving or not but was told it seemed to be improving.</p> <p>Observation and interview on 8/20/24 at 2:01 P.M., showed one black fan running in the kitchen. Dietary Aide A said the fan was on because the kitchen was hot. He/She said the Dishwasher/Pot Cleaner cleaned the floors.</p> <p>During an interview on 8/20/24 at 2:06 P.M., the [NAME] E said he/she cleaned the front line at the end of shift. The fan was on to help keep the kitchen cool. The building was old and had cracks for roaches to hide. He/She saw the pest control company before but didn't know how often they came. He/She said maybe every two weeks.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 8/21/24 at 9:42 A.M., the Administrator said staff knew what the cleaning procedure was, and they had been in-serviced. He said the exterminator said the more fans the facility had in the kitchen the better it would be. The Administrator was told dietary staff said they used the fan to cool off the kitchen and not used as an intervention for the roaches to keep the floor dry. He said not all staff had been in-serviced on the purpose of the fan to deep the floor dry as an intervention for roaches. The checklist was just created last week. They would in-service everyone. The Administrator said they started taking the boxes out of the kitchen at night and put them in the storeroom they used to share with maintenance. Bugs like boxes and water, so taking the boxes out at night would give the kitchen a clean slate every morning. The Administrator said he spoke with the owner of the pest control company and was told to keep everything off the floor in the kitchen and to keep it dry. He said the owner of the pest control company suggested using bleach and water for the drains, but he thought that might be bad for the pipes, so he suggested baking soda and vinegar. The Administrator said the night shift dishwasher or floor technician was responsible to use the baking soda and vinegar. Dayshift had a cleaning schedule, but it was different from night shift's deep cleaning schedule.</p> <p>MO00240710</p> <p>MO00240668</p>		