STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265156	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens on the Green	15197 Clayton Road Chesterfield, 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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain and document initial and weekly measurements of pressure ulcers (localized damage to the skin and/or underlying soft tissue, usually over a bony prominence or related to a medical or other device) for one resident (Resident #4). The sample was 8. The census was 118.The Administrator was notified on 11/26/25 of the past non-compliance. The facility has changed their process on how they assess residents at risk for pressure ulcers, as well as their process to document measurements of wounds for residents at risk. Staff were in-serviced on the new process. The deficiency was corrected on 11/17/25. Review of the facility's Pressure Injury Prevent and Wound Documentation policy, dated October 2025, showed:-Purpose: To establish clear guidelines for the prevention, early identification, and management of pressure ulcers (also known as pressure injuries or bed sores) and all residents, thereby promoting skin integrity and improving quality of care; -Complete Braden Scale risk assessment on admission, quarterly, with Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), and with significant change of condition;-Nurse will conduct weekly skin assessments and document findings in the resident's medical chart. Review of the facility's Wound Documentation policy, dated October 2025, showed:-Purpose: To ensure consistent, accurate, and a timely documentation of wound assessment, treatment, and progress in accordance with best clinical practice, regulatory guidelines, and facility standards; -Goal of Assessment: --Provide uniform description;--Facilitate communication among staff;--Adequate monitoring of progress of deterioration;--Assess the entire person not just ulcer;--Assess for pain and implement interventions to relieve;-How to Assess/Document:--Initially assess the ulcer(s) for location, measurements, exudate (fluid that has seeped out of the tissue), and tissue type;--Initiate and complete the Causal Risk Analysis for Pressure Ulcers in the Electric Health Record (EHR) for each pressure ulcer upon initial finding and quarterly. Utilize the finding for development of the care plan;--Weekly reassessment should be done indicating the measurements and other descriptive characteristics consistent with the initial assessment in order to clearly communicate progress or decline;-If an ulcer/wound is assessed as unchanged at the second week assessment, the provider must be notified, and treatment plan reassessed. If an ulcer/wound is assessed as deteriorated, the provider must be notified and the treatment plan reassessed; -Documentation of initial and weekly assessment findings should be noted in the wound management section of the EHR. Review of Resident #4's hospital record, dated 9/24/25, showed:-Consult to wound/skin management;-Wound to scrotum: moisture-associated skin damage (MASD); -Sacral area: due to friction and MASD;-Left trochanter (hip) present on admission measured 4.0 by (x) 4.0 x 0.2 centimeters (cm). Review of the resident's medical record, showed:-Diagnoses included metabolic encephalopathy (neurological dysfunction) and dysphagia oropharyngeal phase (inability to swallow normally); -An admission progress note, dated 9/25/25, in which staff documented an open area to left hip measuring 3.2 x 2.6 cm, to right sacrum measuring 1.0 x 1.0 cm, and to coccyx measuring 3.0 x 0.6 cm;-No other measurements documented until the resident was discharged from the facility on 11/11/25 to the hospital. Review of the resident's electronic physician order sheet (ePOS) and Braden Scale (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observations, showed:-An order, dated 9/25/25, for weekly skin audits on Thursday between 3:00 P.M.-11:00 P.M.;-An order, dated 9/26/25, for complete Braden Scale observation on admission and weekly for four weeks, once a day, every seven days;-No skin assessments documented as completed on 10/23/25 or 10/30/25. Review of the resident's annual MDS, dated [DATE], showed:-At risk of developing pressure ulcers/injuries;-Has one or more unhealed pressure ulcers/injuries;-Has one unstageable pressure ulcer (slough (dead tissue) is present, the actual base and condition of the ulcer cannot be determined). Review of the resident's care plan, in use at the time of survey, showed:-Problem: An unstageable wound to left hip and MASD to sacrum/buttocks, had prior to admission;-Goal: Maintain/improve skin integrity next review;-Approach: Conduct a systematic skin inspection weekly, pay particular attention to the bony prominences; encourage turning and repositioning, provide supplants per physician's order. During an interview on 11/25/25 at 8:00 A.M., the Director of Nursing (DON) said she expects wounds to be documented and measured by facility nurses. It is her responsibility is to ensure the wounds are charted properly, measurements are accurate, and the resident's medical record is updated. The Wound Nurse failed to record or document measurements in EHR. During an interview on 11/25/25 at 12:42 P.M., the Administrator, Regional Nurse A, and DON said the facility failed to complete the resident's skin assessments. The resident was seen by nurse practitioner who specializes in geriatrics (senior population), but facility staff did not complete wound assessments weekly, and the admission audit was incomplete. The facility has a large presence of agency staff and they are not aware of the facility's policies, protocols, and procedures, which hinders facility staff. Regional Nurse A said each nurse's station has a binder with policies and procedures that agency staff can reference. The Administrator said that agency staff is to familiarize themselves with the binder and sign a form of comprehension of facility's policies and procedures. During an interview on 11/26/25 at 8:54 A.M., the DON, Administrator and Regional Nurse A said the Wound Nurse is newer to the role he/she has held the position for two months. The Wound Nurse had on the job training and was sent to train among the different sister facilities. Regional Nurse A said the Wound Nurse is not responsible for daily treatments to residents in the facility. The floor nurses are responsible for daily treatments. The Wound Nurse or designee should always measure residents' wounds, then place the measurements in the EHR. Regional Nurse A said occasionally, this is not documented in real time and there is a delay in entering the data. 2666564