STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265310	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens South	5300 Butler Hill Road Saint Louis, MO 63128

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to ensure one resident (Resident #1) received adequate assistance to prevent accidents when staff performed a Hoyer (mechanical lift) transfer with a torn Hoyer sling on 05/06/26 after staff observed a tear in one of the straps of the Hoyer sling. All four Hoyer straps ripped during the transfer and the resident fell to the floor which resulted in fractures to both of the resident's femurs (the upper leg bone, that is the longest and strongest bone in the human body and is the structural link between the hip and knee) that required surgery. The sample was 6. The census was 232 with 174 residents in certified beds.The Administrator was notified on 06/11/26 of the Immediate Jeopardy (IJ) past non-compliance, which occurred on 05/06/26. The facility completed an audit on Hoyer lift slings and disposed of equipment that was not intact. Nursing staff were in-serviced on resident transfers, including inspection of transfer equipment prior to use. The deficiency was corrected on 05/19/26. Review of the facility's Mechanical Full Body Lift policy, effective date 11/2025, showed:-Purpose: To ensure that all nursing staff are using proper transfer techniques to minimize the risk of injury to residents and staff, while using full body lift;-Procedure:--1. Gather necessary equipment. Make sure you are using the correct sling for the lift selected;--2. Confirm compatibility between the connection style of the patient sling and the patient lift;--3. Every sling should be inspected before use for safety purposes;---Inspect for tears or fray;---Inspect for missing tags;---Inspect for loose, missing, or torn stitching;---Inspect for discoloration;---If any of the above listed are found, the sling is no longer safe to use and must be replaced. If you are unsure of the condition, please take the sling to the Director of Nursing (DON) or Administrator for guidance. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 04/27/26, showed:-Cognitively intact;-Upper extremity impairment on one side and lower extremity impairment on both sides;-Dependent on assistance with showers/bathing and chair/bed-to-chair and tub/shower transfers;-Diagnoses included quadriplegia (partial or total paralysis of all four limbs (both arms and both legs) and the torso). Review of the resident's care plan, revised 04/29/26, showed the resident required assistance of two staff with full body lift for transfers and mobility. Review of the resident's progress note, dated 05/06/26 at 4:00 P.M., showed a Certified Nurse Assistant (CNA) alerted Registered Nurse (RN) C the resident was on the floor. RN C and the nurse manager went to the resident's room. Prior to entering the resident's room, the resident was heard yelling and cursing. The resident was lying on his/her right side, with the Hoyer sling intact underneath the resident. The resident complained of pain but no obvious head injury. The resident yelled, don't touch me and refused assessment. Emergency medical services (EMS) arrived and transported the resident to the hospital. Review of the resident's hospital record, dated 05/11/26, showed:-History of presenting illness: The patient presented with history of fall from Hoyer lift. While transported from chair to bed, a string tore off and he/she fell from at least four feet high to the floor. The patient was seen in extreme pain during this encounter and requested pain medication during the whole time;-On 05/06/26, CT scan completed, showed bilateral proximal femoral fractures;-On 05/07/26, the resident underwent bilateral hip intramedullary nailing (surgical procedure used to treat fractures of long (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	bones). Review of the facility's investigation conclusion, dated 05/11/26, showed on 05/06/26, CNA A and CNA B transferred the resident to the shower chair using a large mesh sling with commode cut out and the full body lift. During the transfer, CNA A heard a creaking noise. Once the resident was on the shower chair, CNA A noticed one of the lift straps was broken or starting to rip as the aides unattached them from the lift. The shower was completed. The resident mentioned the lift sling seemed worn out. CNA A offered to get the nurse but did not see one nearby. The resident yelled and cursed and told the aides to hurry up and get him/her out of the shower chair. The aides reattached the sling loops to the lift. As they pushed the Hoyer lift toward the resident's bed, the straps snapped and the resident dropped to the floor. Three loops from the sling were left hanging on the lift and lift pad was underneath the resident on the ground. The resident was approximately waist-high when he/she fell to the floor. He/She immediately complained of significant pain, particularly to his/her lower back. EMS picked up the resident. At the time of the hospital transfer, resident's cognition did not change from baseline and he/she was responding appropriately. On 05/07/26 per hospital records, the resident sustained bilateral femoral fractures with potential plans for surgical intervention of bilateral hip nailing. Review of CNA A's written statement, dated 05/06/26, showed CNA A was with the resident during the incident. He/She was giving a shower. He/She was finishing the resident's shower, getting ready to put the resident in bed, and the Hoyer lift broke. He/She thought the part by the lower leg broke first while in the shower. During an interview on 06/10/26 at 11:12 A.M., CNA A said he/she assisted with the Hoyer transfer from the resident's bed into the shower chair. When the resident was transferred from the bed to the shower chair, one of the loops on the Hoyer sling began to tear. CNA A was going to show the nurse when he/she passed the nursing station on the way to the shower room, but the nurse was not at the nurse's station. After the resident received his/her shower, CNA A brought the resident back to his/her room in the shower chair. The sling was hooked up to the Hoyer and the loops directly attached to the Hoyer lift were intact. CNA A told the resident he/she wanted to get management to look at the sling and the resident told CNA A to put him/her in the damn bed. CNA B was assisting with the Hoyer transfer and used the remote to lift the resident. CNA A removed the shower chair after the resident was lifted to bed level. CNA A and CNA B attempted to move the resident over to the bed and all of the loops on the Hoyer sling broke and the resident fell to the floor. Review of CNA B's written statement, dated 05/06/26, showed a shower had just been finished before the time of the fall. The fall occurred when transferring the resident from the shower chair to the bed with the Hoyer lift. When being raised with the Hoyer, all four straps ripped apart from the pad that was underneath the resident. During an interview on 06/10/26 at 11:45 A.M., CNA B said he/she assisted CNA A with the resident's Hoyer transfer. Prior to the Hoyer transfer, the resident made a comment about sling and said it seemed wore out. CNA A said he/she could go and get management to assist and the resident said, Just do what you have to do. CNA B did not see anything wrong with the sling. He/She began lifting the resident up with the Hoyer and CNA A removed the shower chair, then all of the straps broke and the resident fell to the floor. The straps remained connected to the Hoyer when the resident fell, and the sling separated from the straps and the sling was underneath the resident on the floor. During an interview on 06/11/26 at 10:25 A.M., RN C said CNA A and CNA B did not report any issues to him/her about the Hoyer sling prior to the resident falling during the transfer. During an interview on 06/10/26 at 4:00 P.M., the [NAME] President of Clinical Operations (VPCO) said the staff initially looked for the nurse, and the nurse was not at the nurse's station. The resident's personality was not one that wanted to wait. The resident voiced that he/she did not want to wait in the shower chair, so the staff made the decision to use a different loop on the sling. The staff felt like it was safe to transfer at that point and lifted the resident and all the straps broke, and the resident fell. Once the staff observed one of the straps on the pad was broken, her expectation was for the staff to find their supervisor and ask for direction and guidance to determine how to safely get the resident from point A to point B. During an interview on 06/11/26 at 10:03 A.M., the Nurse Practitioner (NP) said she expected staff (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	not to use any faulty or broken equipment to transfer residents. Staff should not have used the sling to transfer the resident after identifying that one of the loops were torn. 30064483028145