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	09/17/2024

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 37681 Based on observation and interview, the facility failed to post in a place readily accessible to residents, family members, legal representatives of residents and visitors the results of the most recent survey and complaint investigations. The census was 240 with 184 in certified beds. Observations on 9/11, 9/12, 9/13 and 9/16/24, showed no visible survey results maintained at the entrance of the building, in the lobby of the building or at the desk with the receptionist. No visible signs were posted for the location of the survey results and/or availability of the last survey or complaint investigations. During a group interview on 9/13/24 at 10:54 A.M., nine residents, who the facility identified as alert and oriented, attended the group meeting. Eight residents said they did not know where the survey binder was located and had never viewed it. One resident said the binder and a sign used to be maintained at the receptionist desk at the front lobby, but he/she had not seen it over the last few weeks. Observation and interview on 9/17/24 at 9:12 A.M., showed no visible sign or survey binder maintained at the front lobby desk. The receptionist said the binder was usually kept at the desk, but she could not locate it, or the sign indicating the results were available. The receptionist said It was just here last week. As she looked for the binder, the surveyor located the binder on the desk, underneath a glass shelf, with two other binders on top of it. The receptionist then located the sign underneath another sign. The receptionist said the binder and sign had been there the entire time, but were not accessible to residents, visitors and family members. The survey sign somehow got stuck underneath another sign. During an interview on 9/17/24 at 1:10 P.M., the Administrator said the binder was kept in the front lobby near the receptionist area, along with the sign indicating results were available. It had been there the entire time and was accessible to residents, families and visitors. When told it was not there during observations, she said it was available.

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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 36151 Based on observation, interview and record review, the facility failed to ensure each resident receives adequate supervision and assistance to prevent accidents when a Certified Nursing Assistant (CNA) failed to ensure two staff were present before providing care, which resulted in a fall where the resident suffered a skin tear to the left upper extremity (LUE), a purple bruise purple above his/her left eye with a laceration on top of the bruise (Resident #33). The census was 240 residents, with 184 in certified beds. Review of the facility's Transfer and Lift Policy (butterfly), dated February 2020, Reviewed on May 2021, showed: -Policy: 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 acknowledgment that this facility has adopted a NO LIFT policy for residents requiring a mechanical means of transfer. Upon admission each resident will be assessed by the inter-disciplinary team on the capabilities of how the resident transfers; this will be re-assessed with changes in condition and at the quarterly care plan; -A butterfly magnet will be placed inside of the resident's room on the overhead light or door frame of resident's rooms indicating how the resident transfers. The butterfly will be coded to inform the staff of transfer ability. An additional red dot sticker will be placed on the magnets to indicate two people for ALL MEANS OF TRANSFER AND BED MOBILITY; -A teal butterfly indicates that NO ASSISTANCE REQUIRED; -An orange butterfly indicates a ONE PERSON TRANSFER with gait belt; -A purple butterfly indicates a TWO PERSON TRANSFER with gait belt; -An aqua butterfly indicates that a MECHANICAL FULL BODY LIFT IS Required; -A Red dot indicates TWO people required for ALL MEANS OF TRANSFERS AND BED MOBILITY; -The resident's transfer ability will be indicated in the resident's orders and included on the resident profile and care plan, as well as the butterfly; -All staff involved in the transfer of Residents will be trained on each lift including return competency demonstration; -Any change in resident condition will immediately be reported to the charge nurse if that change in condition affects the resident's current ability to assist in transfers; -When using a mechanical lift to transfer Residents. two employees are required to assist in the transfer without exception; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-All staff involved in the transfer of Residents will be responsible for knowing how to identify transfer status of each resident; -All assisted transfers and ambulation of a resident require the use or a gait belt. Proper placement of the gait belt should be ensured before assisting Resident; -Any infraction of this policy will be reported to the Director of Nursing/Nurse Manager and/or the Administrator. Review of Resident #33's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/2/24, showed: -Moderately cognitively impaired; -Upper extremity/Lower extremity, impairment on one side; -Dependent on staff for all activities of daily living (ADL, self care); -Mobility, rolling left to right; Dependent on staff; -Falls since admission or prior assessment, no; -Diagnoses included stroke, heart disease, kidney disease, respiratory failure, hemiplegia (paralysis of one side of the body), anxiety and depression. Review of the resident's care plan, in use during the survey, showed: -Problem: ADLs, requires full body lift with large cloth full body sling with transfers and mobility. Requires assist of TWO for ALL bed mobility. Dependent with dressing bathing and toileting provided. He/She is not able to ambulate at this time; -Goal: Will demonstrate increasing strength, safety and independence in ADLs by next review date -Approach: Therapy to evaluate. Likes to go to bed early at night, to recline in his/her Broda (a wheelchair for comfortable long-term seating, reduces the number of falls that residents face. Broda chairs offers tilt, recline and adjustments that are operated by gas cylinders) if he/she is not in bed and prefers to be in his/her room. -Problem: Incontinence, Bowel and/or bladder, is incontinent and requires dependent assistance with mobility and hygiene. Requires assist of two with bed mobility; -Goal: Will not exhibit skin breakdown, urinary tract infection (UTI), impaired social interaction, lowered self-esteem secondary to incontinence through next review; -Approach: Answer call light promptly. Keep call bell within reach. Offer toilet upon risking, after meals, evenings, every time when making rounds at night, and as needed. Check for incontinence; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Problem: Falls, is at risk for falling due to history of falls, psychotropic (drugs that affect a person's mental state), hemiplegia (paralysis of one side of the body), weakness, decreased safety awareness, non-compliance with waiting/asking for assist and unsteadiness. Soft touch call light. Ensure proper alignment and positioning during transfers; Bariatric bed (plus sized) with bolster (raised wedges on either side of the bed); Goal: Will not have falls/injuries through next review; -Approach: CNA changing resident, while providing care resident began shaking and rolled out of bed. Bariatric bed with bolster. Review of the resident's nurse's progress notes, showed: -On 7/6/24 at 6:59 P.M., this nurse was alerted by CNA that resident rolled out of bed while being cleaned up, he/she said he/she was shaking while being cleaned which was confirmed by other CNAs that resident always shakes while being cleaned up. Neuro check (a routine neurological exam), performed and all normal range (WNR). Resident received a skin tear to Left shin and a bruise to the forehead along with a scratch. Resident's Responsible Party and Physician were notified; -On 7/6/24 at 7:33 P.M., physician gave orders to send to hospital since resident hit his/her head. 911 notified and here to pick resident up. Family notified and is not very happy due to fall. This nurse explained what was told by CNA, he/she was shaking and rolled out of bed during care. Family still unhappy. Resident being sent the hospital for evaluation; -On 7/7/24 at 6:24 A.M., received call from the hospital. Resident has no broken bones, a CT scan(computed tomography scan medical imaging procedure that uses X-rays and a computer to create detailed images of the inside of the body) of the head and spine, chest x-ray, and urinalysis (UA) all came back negative resident is on his/her way back to the facility; -On 7/7/24 at 7:50 A.M., resident returned from hospital about 7:15 A.M., via stretcher. Resident currently denies pain but kept asking questions related to fall yesterday. Vitals and neuro check both WNR. No distress noted. Skin assessment complete. Skin tear to left upper extremity (LUE), bruise purple in color noted to left side of face above left eye, and a laceration above left eye on top of bruise. Safety measures in place. Bed low to ground. Frequent rounds made. Review of the facility Post Fall Assessment, dated 7/6/24, completed at 6:51 P.M., showed -Location of fall, resident room; -What was resident doing just prior to fall, laying in bed; -Witnessed fall, yes; -Description of incident; CNA was changing resident and said when he/she was wiping the resident, the resident was shaking and rolled out of bed; -Immediate interventions taken to promote resident's safety, pain management assessment; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Was there an injury? Yes, skin tear to left shin, bruise to forehead with a scratch; -Did the resident hit their head; Yes; -Fall with Suspected head trauma, Neuro checks, skin assessment q shift x 72 hours. Observation and interview on 9/17/24 at 11:03 A.M., showed on the resident's room entrance door frame, an aqua butterfly with a red dot. The resident was seated in his/her Broda chair watching television. He/she remembered when he/she fell out of his/her bed. The resident said he/she had to go to the hospital. He/She said a staff person was taking care of him/her and the staff person rolled him/her out of his/her bed. The resident said the ambulance came and they picked him/her up off the floor and took the resident to the hospital. He/She said he/she hit his/her head, and it was hurting. He/She said they did a CT scan at the hospital to see if his/her neck was broken, but nothing was broken, it just hurt. During an interview on 9/19/24 at 11:08 A.M., CNA F said he/she was in the process of cleaning the resident after the resident had a bowl movement. CNA F said the resident was on his/her side in the bed and he/she was wiping him/her, when the resident started shaking and ended up rolling out of the bed. He/She said the resident did have the bumpers on the side of the bed, but he/she shook a little too hard and went over the bumper. The resident ended up hitting his/her head on the oxygen concentrator beside his/her bed. CNA F said he/she asked the resident if he/she was okay and the resident said he/she bumped his/her head and it was going leave a bad bruise. CNA F went and found the nurse and the nurse assessed the resident. The ambulance came and took the resident to the hospital. He/she said he/she was an agency employee and was not sure if just agency received the assignment sheets or if everyone got an assignment sheet when they arrived. He/She did receive an assignment sheet upon arrival to the facility and was not aware of the meaning about the butterflies. During an interview on 9/17/24 at 11:11 A.M., CNA E, said the resident was a two assist with all ADL care and a two assist with bed mobility. He/she said a red dot on the butterfly above their doorway means a two-assist bed mobility. He/She said when CNAs started their shift, they were given an assignment sheet. The assignment sheet had the butterflies on it and beside each butterfly, it said what the butterflies meant. The butterflies basically told you how to care for the resident. During an interview on 9/17/24 at 11:15 A.M., Registered Nurse G said he/she was not working the day the resident fell . He/She said the resident was a two assist with all bed mobility. The red dot on the butterfly meant two assist for bed mobility. Agency staff were provided an assignment sheet, and the butterflies were on the assignment sheets along with the definitions for the butterflies. During an interview on 9/17/24 at 11:20 A.M., CNA H said the assignment sheet gives you a low down on your hall. It's basically a whole packet, it tells you how they eat, transfer, lift, it has butterflies on it and tells you the meanings of the butterflies and dots. Basically, it you walk in and don't know anything, it gives you a run down on the resident and how to provide care. During an interview on 9/17/24 at 11:27 A.M., the MDS Coordinator said the resident was a two-person bed mobility, which meant a two person assist providing care in the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/17/24 at 11:30 A.M., the Director of Nursing said the resident was a two person assist at the time of the incident and the CNA was sent home following the incident. The CNA was suspended pending the investigation. She believed the CNA was made a Do Not Return (DNR) for not following transfer policy/protocol. During an interview on 9/17/24 at 1:04 P.M., the Administrator said she expected staff to follow the transfer policy and the resident's care plan.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45083 Based on observation, interview and record review, the facility failed to label and store medications according to acceptable standards of practice, for two of seven medication carts reviewed. The facility failed to date insulin pens when removed from the refrigerator and placed in the medication cart. In addition, the facility failed to ensure narcotic medications were always maintained under double lock when not under direct supervision. The facility identified 14 medication/treatment carts. The census was 240 with 184 in certified beds. Review of the facility's Insulin Administration via Pen Devices Policy, reviewed on ,d+[DATE], showed: -Purpose: To safely administer insulin via pen devices according to physician orders and the facility's Policy and Procedure recommendations; -Procedure: Insulin pens containing multiple doses of insulin are meant for use on a single person only and should never be used for more than one person, even when the needle is changed. Insulin pens should be clearly labeled with the person's name or other identifying in information to ensure that the correct pen is used only on the correct individual. Insulin pen needles are also intended only for a single person; they will be provided in a baggie or box labeled with the individual resident's name. They should be kept separate from other resident's needles and stored in the treatment cart; -Check the expiration date. If a new pen is being utilized for first time, date the pen on the label. Please refer to chart for pen expiration dates. Pens should be stored in the refrigerator prior to use and kept in the labeled Ziploc bag in which they were delivered. Once used, they must be kept at room temperature in the treatment cart. Review of the facility's Quick Reference for Insulin Pens, last updated [DATE], showed expiration days after first use on the following type of insulin: -Humalog Kwikpen (same as Insulin Lispro, short-acting, pre-filled, disposable insulin pen that helps control blood sugar spikes after eating) - expires in 28 days; -Tresiba FlexTouch Pen (insulin degludec, a long-acting, man-made version of human insulin) - expires in 56 days; -Lantus SoloStar pen (a long-acting man-made-insulin used to control high blood sugar in adults and children with diabetes) - expires in 28 days. Review of Insulin Lispro pen instructions for use, showed: -Do not use your pen past the expiration date printed on the label or for more than 28 days after you first start using the pen; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Store unused pens in the refrigerator; -In-use pens: Store the pen you are currently using at room temperature; -Throw away the Insulin Lispro pen you are using after 28 days, even if it still has insulin left in it. Review of insulin degludec pen guide for patients, showed: -Before first use: Store in a refrigerator; -After first opening: Keep it at room temperature or in a refrigerator up to 8 weeks. Review of the Lantus insulin pen how to use instructions, showed: -Before opening, store Lantus in the refrigerator; -Always store unopened Lantus in the refrigerator; -Always check the expiration date of the pen; -Never refrigerate the pen after opening it; -After its first use, keep at room temperature. After 28 days, throw your opened Lantus pen away, even if it has insulin in it. Review of the facility's Controlled Drug Medications Policy, reviewed ,d+[DATE], showed: -All controlled medications must be stored in a separately locked area that requires a different key; -Scheduled II (drugs can cause severe psychological or physical dependence, include certain narcotics, stimulants, and depressant drugs) medications remain in a double locked cabinet in the med room or in a locked container on the nurses- treatment cart; -Scheduled III (Opioid analgesics in this schedule include products containing not more than 90 milligrams of codeine per dosage unit and buprenorphine), IV (drugs with a low potential for abuse and low risk of dependence.), and V (drugs with lower potential for abuse and consist of preparations containing limited quantities of certain narcotics) routine medications be placed in a locked box on the medication cart; -Schedule III, IV, and V PRN (as needed) medications will be stored in a locked cabinet inside the medication room if there is not adequate separately locked storage available on the medication cart. 1. Observation on [DATE] at 9:08 A.M., of the Division 400 nurse cart, showed: -11 insulin pens, stored in individual containers for each resident; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One insulin lispro pen with no date removed from refrigeration or expiration date labeled on the pen; -One insulin degludec pen with no date opened or expiration date labeled on the pen; -One insulin Lantus with no date removed from refrigeration or expiration date labeled on the pen. During an interview on [DATE] at 9:08 A.M., Licensed Practical Nurse (LPN) A said staff should label the insulin pens when they are removed from refrigeration. He/She wrote the date on the pharmacy label, but some staff will label the pen itself. He/She looked at the three pens and verified no dates were written on the pens. 2. Observation on [DATE] at 9:25 A.M., of the Division 500 Certified Medication Technician (CMT) cart, showed no staff at the cart or in direct view of the cart. At 9:30 A.M., CMT B said the medication cart was for residents who resided in rooms a ,d+[DATE]. He/She unlocked the cart. Observation showed a narcotic box inside the cart unlocked. Multiple cards with narcotic medications were inside the box. CMT B said staff had to push down on the top of the lock box until it clicked, to get the narcotic box to lock. It should be locked anytime staff were away from the cart. 3. During an interview on [DATE] at 8:08 A.M., LPN C said insulin pens should be dated and labeled once opened and removed from the refrigerator, using a permanent marker or pen. The expiration dates would depend on the type of insulin. The Quick Reference Sheets were available in the medication room and carts for staff to refer to determine the expiration dates. The insulins should be discarded after date of expiration. LPN C said if insulin pens were not labeled, he/she would find out who opened the pen and it would be discarded immediately if no sufficient information was gathered. LPN C said narcotics should be locked at all times. 4. During an interview on [DATE] at 9:03 A.M., Registered Nurse (RN) D said once insulin pens were opened and removed from the refrigerator, they should be dated and initialed by the staff who opened the pen. Expiration dates would depend on the type of insulin. The Quick Reference sheets for insulin pens were available in the nurses' carts. RN D said the narcotic medications should always be locked in the drawer in the medication cart. 5. During an interview on [DATE] at 11:30 A.M., the Director of Nursing (DON) said she expected insulin pens to be labeled and dated when opened and removed from the refrigerator. Expired insulin pens should be discarded. The narcotic medications box should be locked at all times.