STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265325	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens North	4401 Parker Road Black Jack, MO 63033

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure all residents were treated with dignity and respect, ensuring their comfort, privacy, and personal rights are always upheld, when staff did not knock or announce their presence before entering the rooms of Residents #36, #50, #72, and #84, violating their right to privacy, when Residents #1, #2 and #28 were not provided with call lights within reach, limiting their ability to communicate their needs promptly and when staff failed to adjust the dining room temperature to a comfortable level, compromising their comfort for Residents #26, #72, #145, and #164. This affected the dignity standards to guarantee residents' physical comfort, autonomy, and respect in daily care for nine of 36 sampled residents. The census was 171. Review of the facility's undated Resident Right policy, showed:-Dignity and Respect: Resident has the right to expect the surroundings are safe, clean, and comfortable;-Privacy and Confidentiality: Resident has the right to privacy and confidentiality during persona visits; - Visitors and Communications: Staff respect the personal character of visits and correspondence. Review of the facility's Call Light - Answering policy, dated June 2021, showed:-Purpose: To get the resident when he/she calls for assistance and to assist the nurse in meeting resident's requests.-Procedures: Check to see if he/she call light is within reach. Review of the facility's Resident Council Minutes, dated June 30, 2025, showed the residents voiced concerns that call lights were not answered in a timely manner. 1.During observation and interview on 9/18/25, showed: -At 8:10 A.M., Resident #72 sat at a bedside table eating breakfast. The bedroom door was to the right side of the resident and closed. The resident was startled when the door opened without notice. Housekeeper (HSKP) O walked in carrying a vacuum while talking on a cell phone. HSKP O said, I need to vacuum, it will only take a minute. HSKP O started to vacuum as he/she continued to talk on his/her phone. HSKP O vacuumed around the resident and surveyor. The resident was unable to hear over the vacuuming and HSKP O's phone conversation. Resident rolled his/her eyes and said I get so frustrated; they do this all the time. They never knock and always on their phones. The resident and surveyor resumed their visit after HSKP O left the room;-At 11:08 A.M., Resident #36 closed his/her bedroom door to visit with a surveyor in private. Certified Nurse Aide (CNA) L entered resident's room without knocking or explaining why he/she was in the room. CNA L walk between the resident and surveyor and started gathering supplies. CNA P remained in the doorway. The resident sat in a wheelchair with his/her left shoulder facing the doorway. The surveyor sat on the bed and faced the resident. CNA L spoke to CNA P across the room about what personal care supplies were needed and did not acknowledge the resident or surveyor. CNA L told the surveyor the resident needed to be changed if he/she would step out;- At 11:28 A.M., Resident #36 said the staff never knock before they come in his/her room. There was no use to complain because the staff do not care. During an interview on 9/23/25 at 9:30 A.M., Resident #84 said his/her only complaint is when the staff come into his/her room and do not knock or announce themselves. Resident said last week he/she was in bed on his/her side with his/her back to the door when he/she rolled over and was scared half to death to see a CNA there next to his/her bed. During interview on 9/23/25 at 1:15 P.M., Resident #50 said last week, a man came into (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	his/her room and did not knock or introduce himself and went straight into the bathroom. The resident said, I normally don't cuss but it scared me to death that I yelled, what the hell are you doing! The resident said the man said, I am just checking things out. The resident said he/she was so upset he/she told his/her roommate who went to the nurses' station and was told the man was from nursing. The resident said the staff should knock before coming in their room. During an interview on 9/23/25 at 9:05 A.M., Housekeeper (HSKP) N said before entering a resident's room, staff need to knock and announce who they are and wait for a response. If the resident has a visitor, they should be asked when they would like staff to return. Review of Resident #2's quarterly MDS, dated [DATE], showed:-Moderately impaired cognition;-Diagnoses included left side paralysis, chronic kidney disease, legal blindness, and urine retention. Observation on 9/23/25, showed Resident #2 in his/her room and the following:-At 7:24 A.M., Resident was awake lying on his/her back in bed. The resident winced and said he/she wanted to be repositioned. He/She pushed his/her call light;-At 7:28 A.M., the resident called out, Nurse please help me; -At 7:28 A.M., CNA R walked into the resident's room without announcing who he/was, while hanging up a phone call on his/her cell phone, turned off the call light, and told the resident he/she is going to go get some help and walked back out of the room;-At 7:29 A.M., the resident turned the call light back on;-At 7:35 A.M., the resident called out, please can I be turned; -At 7:37 A.M., the resident called out, help me please. He/She winced in pain while he/she attempted to reposition him/herself;-At 7:39 A.M., the resident called out, please help me.; -At 7:41 A.M., the resident called out, please somebody help me, Nurse please. The resident started crying; -At 7:45 A.M., CNA R came back to the resident's room. During an interview on 9/25/25 at 12:04 P.M., the Director of Nursing (DON) and Administrator said they expected staff to introduce themselves and what they are doing when speaking to all residents, but especially residents with visual impairment. They expected CNA R to assist the resident in a timely manner if the resident was visibly in pain. 2. Observation on 9/18/25 through 9/25/25, showed:-9/18/25 at 8:30 A.M., Resident #28 sat in his/her recliner. The call-light lay at the foot of the bed out of reach. The resident yelled for someone to get him/her more coffee;-9/18/25 at 8:35 A.M., CNA L entered Resident #8's room, placed coffee on the bedside table and exited the room. The call-light remained out of reach;-9/18/25 at 10:15 A.M., Resident #1's call-light at the foot of bed by his/her feet;-9/19/25 at 6:49 A.M., Resident #1's call light out of sight;-9/19/25 at 12:45 P.M., Resident #28 yelled out for more coffee to staff as they passed his/her room. The call-light lay at foot of the bed out of resident's reach;-09/19/25 at 1:05 P.M., Resident #1's call-light was out of reach, at the foot of the bed;-9/22/25 at 9:15 A.M., Resident #28 yelled out to two staff members Hey you, I want more coffee. Both staff members continued to walk down the hall. The call light laid at the foot of the bed and out of the resident's reach;-9/23/25 at 6:25 A.M., Resident #1's call-light lay at the foot of the bed;-9/25/25 at 08:18 A.M., Resident #1's call-light was coiled up by his/her feet at the end of the bed. During an interview on 9/22/25 at 6:20 A.M., Resident #1 said the call-light does not work. CNA B lifted the bottom of the mattress to reach his/her call-light that was stuck. CNA B draped the call-light across the resident's body. During an interview on 9/22/25 at 10:30 A.M., two of the resident's family members said the resident's call light is frequently out of reach, which has been brought up to the nursing staff. One of the family members said recently during a visit he/she observed Resident #28 yell out to staff, who stopped and looked at the resident but kept going. The family member said this was reported to the Director of Nursing (DON) that day, who said it would be addressed, but they felt it has not improved. During interview on 9/23/25 at 06:25 A.M., Licensed Practical Nurse (LPN) A said when Resident #1 is rolled, he/she can get the call light stuck. 3. Observation of the 400 hall dining room temperatures on 9/19, 9/22 and 9/23/25, showed:-9/19/25 at 7:50 A.M., Residents #72, #145 and #164 were in the dining room at a table that was placed approximately two feet under ceiling supply vents that blew cold air. The residents said it was cold. The thermostat setting was 73 degrees Fahrenheit (F);-9/19/25 at 8:56 A.M., showed the ceiling supply vents in front of the dining room windows blew cold air at 69.87 F; air flow was taken with electric Eray Humidity meter. The air flow was directly (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	felt by all three table occupants who were seated along the vents. The wall thermostat showed a setting of 73 degrees F.-9/22/25 at 7:55 A.M., Residents #26, #72, #145 and #164 said the dining room was too cold and they wished staff would put something over the vents;-9/22/25 between 7:55 A.M. and 11:49 A.M., Resident #26 sat in unit 400 hall's dining room at a table that was placed approximately two feet under a ceiling supply vent which blew cold air. At 7:58 A.M., the resident asked CNA K to adjust the temperature because he/she was too cold. CNA K yelled out to Licensed Practical Nurse (LPN) G to call maintenance to adjust the temperature. The thermostat setting was 73 degrees F. From 8:15 A.M. until 11:49 A.M., the dining room temperature had not been adjusted.-9/22/25 at 9:13 A.M., Maintenance K approached the unit 400 hall nursing desk located in front of the unit 400 hall dining room, stopped briefly then continued down another hallway, away from 400 hall dining room. He/She did not adjust thermostat as previously requested by the resident. During an interview on 9/18/25 at 9:45 A.M., Resident #26 said the dining room is too cold for him/her to enjoy the food because the food gets cold too quickly. The resident said it is because the ceiling supply vent blows directly down on him/her. He/She said all the residents who sit under the vents often complain and ask staff to adjust the temperature during meals, but no one listens or cares. During an interview on 9/23/25 at 9:05 A.M., Maintenance A said residents are known to complain the dining rooms are too cold. When the nursing staff let maintenance know, they will adjust the temperature. Maintenance A said he/she was not made aware residents on the 400 hall were complaining the dining room was cold but it is hard to control the temperature since the vents blow directly down on a few of the tables. 4. During an interview on 9/22/25 at 9:35 A.M., CNA K said he/she was aware it gets cold in the dining room, but it is the vents that blow down on the residents. When the residents complain, they will tell maintenance to come and adjust the temperature. CNA K said it would be helpful if they could move the tables so they would not be directly under the vent. CNA K said before anyone enters a resident's room, they need to knock and announce themselves. If a resident has a visitor, staff should ask if they want staff to come back. CNA K said before he/she leaves a resident's room, he/she makes sure the resident has their call light within reach. 5. During an interview on 9/22/25 at 10:05 A.M., LPN G said ultimately, it is the CNA's job to ensure resident's call lights are within reach, but all staff should be looking before they leave a resident's room to ensure the call light is within the resident's reach. LPN G said staff should knock before entering a resident's room and if they have a visitor, they should ask the resident when a good time would be to come back. If a resident or staff have a concern with maintenance issues, staff will call maintenance. LPN G said the maintenance is good about addressing any issues quickly. 6. During an interview on 9/25/25 at 10:30 A.M., the Administrator said the facility does not have a policy on reporting maintenance issues. All maintenance issues are reported to maintenance immediately by calling overhead or reporting to the receptionist who fills out a work order slip. The work order slips are kept at the receptionist desks. The Administrator said she expected staff to follow the Call Light - Answering policy by ensuring resident call lights are within reach. The Administrator expected all staff to knock and announce who they are before entering a resident's room. If the resident has a visitor, staff should ask the resident if they should come back.

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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. Based on observation, interview and record review, the facility failed to maintain a clean or organized medication cart and storage rooms within the facility. Four out of seven carts were checked. Staff failed to ensure proper storage and labels on medications on four Certified Medication Technician (CMT) medication carts. The census was 171. Review of the facility's Medication Storage Policy, dated December 2021, showed:-Drugs and medications are to be stored in the original container in which they were received;-Only the charge nurse or medication nurse has access to the narcotics keys,-Now discontinued, outdated, or deteriorated drugs or medications will be stored in the facility over thirty (30) days.-Medications which require refrigeration are kept in the refrigerator in the locked medication room. Drugs stored under the refrigeration are stored separately from food, -Compartments and areas containing drugs are locked when not in use or when left unattended. Such areas included drawers, cabinets, rooms, refrigerators, carts and boxes. 1. Observation of the 100-hall medication CMT F cart on 9/19/25 at 6:30 A.M., showed:-A total of 40 pills with various colors, shapes and sizes under the white pull-out tray;-The second drawer had 13 pills of various colors, sizes and shapes;-Thirty pills at the back of columns;-Metamucil 4-1 fiber canister open without a date;-Polyethylene glycol without an open date;-The narcotics drawer had an herbal supplement jar with loose change and dollar bills inside of it. Observation of the 100-hall storage room on 9/19/25 at 6:30 A.M., showed vitamin C 500 was open, and 12 pills were left in the bottle without an open date. The bottle was in the overstock cabinet. During an interview on 9/19/25 at 6:32 A.M., CMT D said he/she tried to clean out their cart. There are 2-3 times weekly checks, with the pharmacy coming out monthly. CMT D said sometimes staff pop out medications, and they attempt to locate the medicine but cannot always find the pill in the cart. 2. Observation on the 200 hall CMT E cart on 9/19/25 at 7:40 A.M., showed: -The top drawer has 4 double D batteries, and several double A batteries;-A personal fan located in the third drawer;-Three aerosols with floral smells. During an interview on 9/19/25 at approximately 8:00 A.M., CMT E said staff used the batteries for the weight scale in the halls. He/She removed them from the cart. The CMT grabbed the plastic fan and said, That is mine, I will remove it. 3. Observation on the 300-hall nurse cart on 9/19/25 at 8:20 A.M., showed:-Polythene Glycol without an open date;-Two pills with markings of O25 white circular score (easily cut in half), one long yellow marked 100/ GG 335, one grey/brown pill, 894/5 peach/pink long pills;-A phone charger in the third drawer. During an interview on 9/19/25 at 8:20 A.M., Licensed Practical Nurse (LPN) F said the pills must have fallen out when they were popped into the medicine cup. The nurse in charge of their cart should clean out the cart. 4. Observation on the 400 hall CMT cart on 9/19/25 at 8:41 A.M., showed:-The third drawer has three long white pills, one blue pill and one peach pill;-Fourth drawer: seven pills in total, in various sizes and colors. During an interview on 9/19/25 at 8:41 A.M., LPN G said he/she believed CMTs or management cleaned out the medication carts but was unsure. LPN G said he/she believes whoever is on the cart would be responsible for cleaning the cart. 5. Observation on the 500 hall CMT cart on 9/19/25 at 9:08 A.M., showed:-The top drawer had three loose white pills;-The second drawer, the fourth column, had over 50 pills in various sizes, colors, shapes, and capsules;-Third drawer had 13 loose pills of various sizes and colors;-The fourth drawer had four loose pills in total, in various sizes and colors. During an interview on 9/19/25 at 9:13 A.M., LPN I said CMTs, LPNs and Registered Nurses (RNs) are responsible for cleaning the carts. During an interview on 9/19/25 at approximately 9:15 A.M., the Unit Manager said medications carts are cleaned on a regular basis but was unable to define what regular meant. He/She expected no pills to be found on the cart. However, this second drawer, with over 50 pills, was less than satisfactory. He/She said the third drawer should have no pills. During an interview on 9/19/25 at 11:50 A.M., the Director of Nursing (DON) said he/she expected staff to follow policies and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	procedures, and it is up to the CMT, LPN, and RNs to clean the carts as needed or daily if they see medication laying out. The DON's expectations are no personal items are to be found on medication carts.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's Against Medical Advice (AMA) discharge was documented in the medical record and appropriate information was communicated to the resident and/or responsible party. The facility also failed to maintain a copy of a signed AMA discharge form for one of three residents reviewed for voluntary and involuntary discharge procedures (Resident #178). The census was 171. Review of facility's admission Agreement, showed: -You may voluntarily end this admission Agreement and leave our facility at any time by giving us seven days advance written notice. If you leave against the advice of your physician, you agree to assume full responsibility of all results that follow. You also agree to pay all outstanding charges before you leave. If you die while in our facility, we will honor your wishes and provide assistance to your Resident Representative or to whomever is responsible for making all funeral arrangements.Review of Resident #178's medical record, showed:-admitted on [DATE];-discharged on 7/24/25 at 8:25 A.M., left against medical advice.Review of the resident's progress notes, showed:-On 7/23/25 at 9:42 A.M., patient arrived to facility via Emergency Medical Services (EMS) transport from hospital into bed by EMS staff. Admitting diagnoses abdominal abscess (localized collection of pus that forms in the body's tissues or organs) with history of pancreatic cancer, liver cancer, diabetes, acidosis (too much acid in the body), low hemoglobin (a protein found in red cells that carries oxygen throughout the body), and hypoglycemic (low blood sugar). Alert and oriented x 3-4 (person, place, time and situation), able to express needs but can be forgetful at times. Patient is a regular diet and continent of bladder and bowel. Patient is a full code. All medications verified with physician and faxed to company; -On 7/24/25 at 1010 A.M., for 7/23/25 11:00 P.M.-7:00 A.M. shift, alert and oriented and able to make needs known. Rested in bed during shift. Was incontinent of bowel and bladder and good peri care given; -No documentation of the resident's AMA discharge.Review of the resident's medical record, showed no documentation of the resident's signed AMA form or other documentation of the resident's and/or responsible party's decision to discharge AMA.During an interview on 9/25/25 at 11:27 A.M., the Administrator said she was not familiar with the resident, but the facility has an AMA policy and the resident signs the AMA form. She would expect the resident to sign the discharge AMA form. She would expect staff to document the resident's decision to discharge AMA in the progress notes.On 9/25/25 at 3:00 P.M., at the time of exit, the facility's discharge policy and Resident #178's signed AMA form was not received.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview and record review, the facility failed to document assessments and failed to contact the resident's physician regarding a change of condition for one sampled resident (Resident #11). The sample was 36. The census was 171. Review of the facility's policy, Following Physician's Orders, dated 6/29/21, showed:-Purpose: It is the policy of the community to ensure that all Licensed Professional Nurses (LPNs) Registered Nurses (RNs) and other healthcare professionals, follow physicians in accordance with State, Federal regulations and their respective practice acts.-Procedure: All physicians orders will be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record;--If an order is questionable according to the seven Rights of Medications Administration, a clarification order will be obtained;--All physician or other health care professional's verbal, telephone or written orders will be immediately entered by the nurse obtaining the order. Review of the facility's policy, Wound Management for the Palliative/Hospice Resident, revised date 7/23, showed:-Skin Care and Maintenance of Skin Integrity: --Handle and treat the skin with extreme care;--Cleanse with mild cleanser; avoid the use of soap;--Pay particular attention to high-risk areas sacrum, elbows, and the heels. Review of Resident #11's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/11/25, showed:-Cognitively intact;-Diagnoses included stroke, localized swelling, mass and lump in the left upper limb, polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body). Review of the resident's care plan, in use during the survey, showed:-Problem: Pressure injury at risk of developing alterations in skin integrity and pressure;-Goal: Maintain and improve skin integrity related to risk factors and healing potential;-Approach: Complete bath and skin reports on shower days, communicate with the charge nurse about concerns noted on the skin, floating heels, utilize pressure-reducing devices in bed or wheelchair. Review of the resident's Physician Order Sheets (POS), dated 9/11/25, showed: -Evaluate for left elbow bursitis with a draining abscess per orthopedic follow-up. Wound care initiated and site assessed for drainage and dressing needs. The resident was instructed to use the use of an elbow pad, to be worn at all times except during bathing. Review of the resident's shower sheet, dated 9/13/25, showed left forearm dark purple bruising, elbow pad on, elbow bursitis (a sac of fluid near/by a joint) abscess, right butt cheek small, discolored area. Review of the resident's Medication Administration Record (MAR), showed no assessments during the period of 9/11/25 and 9/24/25. During an interview on 9/18/25 at 10:33 A.M., LPN C said the resident is only monitored for pain and if he/she has their protective elbow brace on daily. LPN C said the resident has a follow-up appointment on 9/24/25. LPN C said nurses are not required to chart color, size or monitor the abscess in any way. LPN C said he/she is unaware if the resident is being followed by wound management at this time. During an interview on 9/22/25 at approximately 11:00 A.M., the Assistant Director of Nursing (ADON) reviewed the specialist orders: Diagnosis of left elbow bursitis with draining abscess. Wound care to evaluate for dressing changes, elbow pad to be worn except baths. The ADON said staff should monitor the site noted on 9/13. The ADON said the order showed for wound management to evaluate the abscess for drainage. Observation on 9/22/25 at 11:07 A.M., showed the ADON and LPN C went to assess the elbow. An adhesive brown bandage was on the site without a date. A small amount of brown dried drainage was present on the bandage. The ADON said he/she couldn't stage the wound due to no prior knowledge of the wound. The wound had a light center and a discolored purple outer center. There is swelling around the site. The ADON said he/she would call the provider to clarify the prior orders. The ADON would put daily monitoring in place and have the wound management provider review the abscess next time they are in. Review of the resident's MAR, showed:-9/22/25 Wound management orders for the left elbow to evaluate and treat. During an interview on 9/25/25 at 11:50 A.M., the Director of Nursing (DON) said all staff members are expected to follow correct policies and procedures when it involves caring for residents. The DON said when wounds are found, staff should report them to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound management. The DON was unaware why LPN C did not clarify the order when the resident came in with an unclear order. The DON said a resident going 11 days without a nurse's care could lead to infection risk. The DON said staff should have charted the wound sooner than 11 days.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 2 of 6 sampled residents the facility identified with a catheter (medical device to allow for voiding) received appropriate catheter care. The facility failed to ensure one resident's catheter was stored properly while the resident was in bed (Resident #2) and failed to ensure one resident received proper catheter care (Resident #55). The sample was 36. The census was 171. Review of the facility's catheter care policy, dated 3/2021, showed:-Purpose: To keep indwelling catheter free of discharge and/or crusting which can cause infections;-Procedure: Check tubing for positioning. Coil on bed. Attach catheter bag to bed frame only.-Male catheter procedure: Apply gloves. Place protective pad or towel under the resident. Avoid unnecessary exposure. Moisten wash cloth with soap and water. Clean the catheter from the opening of the urethra outward four (4) inches, or farther if needed. Do not pull on the catheter. If the male is uncircumcised, the foreskin must be retracted and cleaned. Pat dry with towel. Cover resident. Remove gloves. Wash hands.1. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/24/25, showed:-Moderately impaired cognition;-Diagnoses included left side paralysis, chronic kidney disease, legal blindness, and urine retention. Review of the resident's care plan, in use at the time of the survey, showed the resident's catheter was not identified. Review of the resident's Physician's Order Sheet (POS), dated 9/2025, showed:-An order, dated 5/3/2025, Foley catheter. Observation on 9/18/25 at 8:31 A.M. and at 10:13 A.M., showed the resident lay in his/her bed, asleep. The resident's catheter bag was on the floor next to the resident's bed. Observation on 9/22/25 at 10:20 A.M., showed the resident lay in his/her bed, awake. The resident's catheter bag was on the floor next to the resident's bed. Observation on 9/23/25 at 7: 24 A.M., showed the resident lay in bed, awake. His/Her catheter bag was on the ground next to his/her bed. During an interview on 9/25/25 at 9:19 A.M., Licensed Practical Nurse (LPN) S said when a resident is in bed, their catheter should be placed on the bed frame. He/She expected the catheter to be off the floor to prevent infection and contamination. During an interview on 9/25/25 at 10:10 A.M., Certified Nursing Assistant (CNA) T said when a resident is in bed, their catheter should be placed on the bed frame. He/She expected the catheter to be off the floor to prevent bacteria from getting in the resident's catheter. During an interview on 9/25/25 at 11:58 A.M., the Director of Nursing (DON) and Administrator said they expected catheters to be hung on the bed frame and off the floor when a resident is lying in bed. They expected staff to ensure the catheter placement is correct before leaving the resident's room. 2. Review of Resident #55's admission MDS, dated [DATE], showed:-Cognitively intact;-Indwelling catheter -Diagnoses included cerebral palsy (lifelong impairment caused by brain damage or impairment of development), cognitive communication deficit (impaired thinking or problem-solving), dysphagia (difficulty swallowing), gastrostomy status (surgical site for a tube or other medical device) and aphasia (inability to communicate effectively). Review of the resident's care plan, in use during the survey, showed:-Problem: Urinary tract infection (UTIs) related to blood in catheter,-Goal: The resident will be resolved without complication by the next review date,-Approach: Report and documented to provider regarding signs and symptoms to UTIs like blood in urine, cloudy or sediment (buildup of white substance), encourage resident to pee on first urge rather than holding, given antibiotics as ordered while documenting the side effect and effectiveness, Provie incontinence care after each incontinent episode, teach care givers to provide good hygiene. Females to wipe and cleanse from front to back. Clean peri area well after the bowel movement (BM) in order to help prevent bacteria in the urinary tract. Review of the resident's current POS, showed: -3/5/25, Diagnosis for indwelling catheter: benign prostatic hyperplasia with lower urinary tract (enlargement of the prostate gland).-9/15/25, Bactrim (antibiotic) 1 tablet orally take twice a day for 10 days for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265325	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens North	4401 Parker Road Black Jack, MO 63033

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	UTI.-Catheter care per shift 7:00 A.M. to 3:00 P.M., 3:00 P.M. to 11:00 P.M., 11:00 P.M. to 7:00 A.M. Observation on 9/18/25 at 8:34 A.M., showed CNA Q entered the resident's room to perform care. He/She washed his/her hands and applied gloves. CNA Q wiped the left side and then the right side. CNA Q continued to wipe the genitals. CNA Q touched the indwelling catheter and wiped the middle of the tube in a downward motion. He/She left 2-3 inches of the drain coming from the glans (tip of the penis) untouched. CNA Q put an incontinence brief on the resident. The indwelling catheter was pulled from the left side of the brief draped across exterior of the brief under the right thigh of resident and hung on the right side of the bed. During an interview on 9/25/25 at 9:04 A.M., CNA Q said he/she knows the proper technique to cleanse residents with an indwelling catheter, however he/she did not follow the technique during the care of the resident. During an interview on 9/25/25 at 11:50 A.M., the DON said he/she expected all staff members to follow correct policy and procedures when it involves care for a resident. The DON said residents can be prone to reoccurring UTIs. The DON said there are different techniques for catheter care from men verses women. The DON expected any staff member who provides peri care to a resident to clean the glans and the medical device that is inserted into the urethra. To avoid cleaning the tube, it puts the resident in a situation for bacteria to build up and enter the urethra, which leads to a UTI.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265325	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens North	4401 Parker Road Black Jack, MO 63033

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two residents received gastrostomy tube (a tube surgically inserted into the abdomen, used for liquid nutrition, fluids and medications) feedings at the specified times ordered by the physician (Residents #1 and #55). The sample was 36. The census was 171. Review of the facility's Tube Feeding policy, revised June 2021, showed:-Purpose: to deliver a continuous, regulated drip feeding to gastrostomy tube (g-tube) fed residents using an enteral pump;-Procedure: -Equipment: Enteral pump, enteral feeding bag and administration set; prescribed feeding; and a pole; -Review the physician's orders; The order should specify the amount and type of formula, and the flow rate. Review of the facility's Following Physician Orders policy, dated 6/29/21, showed:-Purpose: It is the policy of the community to ensure that all licensed professional nurses and other healthcare professionals, follow physician orders in accordance to state and federal regulations and their respective practice acts;-Procedure: All physician orders will be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record; If an order is questionable according to the seven rights of medication administration (right resident, right medication, right dose, right time, right route, right documentation, and right reason), a clarification order will be obtained. 1.Review of Resident's #1's admission Minimum Data Sheet (MDS), a federally mandated assessment instrument completed by the facility staff, dated 5/06/25, showed:-Cognitively intact;-The resident has a feeding tube;-Diagnoses include diabetes, venous thrombosis and embolism (a blood clot in the vein or blockage from the clot), hemiplegia and hemiparesis from cerebral infarction (inability to move half of their body from a stroke) and dysphagia (difficulty swallowing). Review of the resident's care plan, in use during the survey, showed:-Problem: Utilizes feeding tube for supplemental nutritional and hydration needs, receives mechanical soft diet as well;-Goal: Maintains current nutritional status and weight through the next review date;-Approach: Administer tube feeding as ordered, flush the g-tube as ordered, allow extra time to eat, assist with mealtime to ensure adequate meal intake. Review of the resident's Physician Order Sheets (POS), dated 5/3/25, showed:-An order, dated 5/3/25, check placement of g-tube placement before feedings and medications administrating by aspirating (pulling back content) stomach before meals at 6:00 A.M., 11:00 A.M., and 4:00 P.M.; -An order, dated 7/8/25, elevated head of bed (HOB) by 30 degrees; -Flush tube with 200 milliliters (ml) of water every six hours and at least 30 ml of water before and after each medication: 7:00 A.M., 1:00 P.M., 7:00 P.M. and 1:00 A.M.;-Glucerna (diabetes specific formula) 1.5 runs at 70 ml per hour daily between 7:00 P.M. and 7:00 A.M.;-Osmolite (calorically dense tube-feeding formula)1.5 in substitute for Glucerna feeding solution;-Formula intake per shift. During an interview on 9/19/25 at 6:49 A.M., the resident said he/she did not get any tube feeding last night. He/She received it the night before but none this morning. The resident was unsure why this happened. Observation on 9/23/25 at 6:25 A.M., showed the resident lay in bed, with the HOB at 30 degrees with no tube feeding running. During an interview on 9/23/25 at 6:31 A.M., Licensed Practical Nurse (LPN) A said the resident's tummy was hurting, and LPN A gave his/her stomach a rest sometimes. There are no orders for symptoms of bloating or distention to follow. Review of the resident's Medication Administration Record (MAR), dated 9/25, showed an order, dated 9/23/25 Glucerna 1.5 ran at 70 ml per hour from 7:00 P.M., to 7:00 A.M.; intake was 840 ml. During an interview on 9/23/25 at approximately 2:00 P.M., the Director of Nursing (DON) said LPN A called the medical provider about the missed tube feeding but was unable to speak directly to the provider or leave a message. The resident complained about distended abdomen and pain, which led LPN A to hold the nocturnal tube feeding. The resident's oral intake for 9/22/25 was 25% at breakfast, 50% at lunch and 75% during dinner. Another nurse attempted to contact the nurse practitioner but was unable to get in direct contact with him/her. The facility's assessment showed (continued on next page)

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	265325	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens North	4401 Parker Road Black Jack, MO 63033

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident had a patent (open) g-tube, bowel sounds and stable vitals. 2. Review of Resident #55's MDS, dated [DATE], showed:-Cognitively intact;-The resident has a feeding tube;-Diagnoses include cerebral palsy (lifelong impairment caused by brain damage or impairment of development), cognitive communication deficit (impaired thinking or problem-solving), dysphagia and gastrostomy status. Review of the resident's care plan, in use during the survey, showed:-Problem: The resident receives all nutrition and hydration via a g-tube. The resident may receive clear liquids as tolerated;-Goal: Will maintain current nutritional status and stable weight;-Approach: Ability to feed yourself, provide a diet as ordered. Review of the resident's POS, dated 2/18/25, showed: -G-tube placement by aspirating the stomach contents every shift day, evenings and nights date 2/18/2025;-Enteral feed: HOB 30;-Enteral Two Cal at 85 ml per hour continuous from 7:00 P.M. - 7:00 A.M., overnight. Observation, showed:-9/19/25 at 6:45 A.M., No tube feeding running and the HOB was at a 45 degree angle. The resident was slumped in bed.-9/22/25 at 6:18 A.M., Osmolite was running 85 mL per hour, volume was 827 mL.-9/23/25 at 6:22 A.M., No tube feeding was running. During an interview on 9/25/25 at 9:02 A.M., the resident said they did not hang his/her feeding tube last night. During an interview on 9/23/25 at 6:31 A.M., LPN A said he/she took the resident off the nocturnal feeding early due to him/her receiving care. LPN A said he/she will remove the tube feeding due to Certified Nurses Assistants (CNAs) in the past pulling the g-tube out. He/She said the resident was hospitalized for the g-tube being displaced in the past. LPN A said the resident received 750 ml of his/her nocturnal feeding. LPN A said the feeding ordered was 1,000 ml. During an interview on 8/25/25 at approximately 2:00 P.M., the DON said she would not expect nurses to discontinue nocturnal tube feeding for care alone. The DON expected staff to pause the pump and resume the nocturnal feeding post-care.