

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2025
NAME OF PROVIDER OR SUPPLIER Delmar Gardens of Creve Coeur		STREET ADDRESS, CITY, STATE, ZIP CODE 850 Country Manor Lane Creve Coeur, MO 63141	

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 0689</p> <p>Level of Harm - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to keep residents free from accidents when staff failed to use safe, professional standards of care when transferring two residents (Residents #1 and #2) using a Hoyer lift (a mechanical device that helps people with limited mobility move from one place to another, such as from bed to a wheelchair). This failure caused an injury requiring hospitalization and surgery for one resident (Resident #1). The facility also failed to investigate two improper Hoyer transfers involving one resident (Resident #2) and did not put corrective measures in place to prevent further injuries to both residents. The sample was three. The census was 88.</p> <p>Review of the facility's Incident/Accident Policy, dated December 9,2016, showed:</p> <ul style="list-style-type: none"> -Purpose: to record any unusual situation or injury to a resident, staff member or visitor; -Examine the person for possible injury; -Administer emergency treatment as indicated; -Notify the physician and responsible party of all incidents of falls and possible head injuries of resident; -Complete Incident/Accident Report Form; -Forward report to appropriate persons per center policy. <p>Review of the facility's Mechanical Full Body Lift policy, dated January 2017, showed:</p> <ul style="list-style-type: none"> -Purpose: To ensure that all nursing staff are using proper transfer techniques to minimize the risk of injury to resident and staff, while using full body lift; -Secure the assistance of another Certified Nursing Assistant (CNA) or other qualified employee; -Positioning of transferring surfaces should be in close proximity to minimize transport area allowing enough room to move base from bed to chair or chair to bed; -Position lift sling (supports resident's weight during transfer) under the resident; <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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident went to his/her meeting after breakfast;</p> <p>-The resident first complained of pain at his/her right lower extremity when he/she returned from his/her meeting around 11:00 A.M.;</p> <p>-The resident said he/she was hit by the Hoyer that morning during a transfer;</p> <p>-CNA D told the agency nurse, LPN C, who came and assessed the resident;</p> <p>-The resident was sent out the hospital.</p> <p>Observation on 1/31/25 at 12:41 P.M., showed the resident lay in his/her bed, with pillows placed under his/her right lower extremity. There was a wound vacuum attached to the resident's right lower extremity wound, actively running. The resident was visiting with a guest and was grimacing in pain.</p> <p>Observation on 1/31/25 at 1:17 P.M., showed the facility's bariatric Hoyer lift in the hall. The remote control to the Hoyer was approximately 10 inches long and two inches wide.</p> <p>During an interview on 1/31/25 at 1:29 P.M., the resident said:</p> <p>-He/She was hurt when staff moved him/her from the bed to his/her wheelchair while using the Hoyer lift;</p> <p>-While the resident was up in the air, one of the two CNAs was pushing on his/her right leg, trying to open the resident's legs up wider;</p> <p>-The CNA had the Hoyer remote control in his/her hand while the CNA was pushing on the resident's right leg;</p> <p>-The resident told them to stop, they were hurting him/her, and to be careful with his/her legs;</p> <p>-The resident told the CNA who was pushing on his/her right leg with the remote control in his/her hand, to stop because the CNA was hurting him/her. The CNA ignored the resident and kept pushing the remote control into the resident's right lower leg;</p> <p>-After the resident was placed in his/her wheelchair, the resident went to the sink to clean him/herself up before going out to the meeting;</p> <p>-During the meeting, the resident's right lower leg started to hurt more and more;</p> <p>-The resident did not want to interrupt the meeting by complaining of pain so he/she was quiet and tried to ignore the pain, which kept increasing;</p> <p>-The resident was in his/her room right after the meeting and decided to look at his/her right lower leg to try to find out why it hurt so badly;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The CNAs did not perform an improper transfer because there were two staff members present, one to control the machine and the other to guide the resident to prevent injury, and they had the Hoyer lift legs open for stability;</p> <p>-She did not write up, counsel or provide in-services to the CNAs involved in the event because they said nothing occurred that could have caused injury to the resident;</p> <p>-Injury of unknown origin was when the facility had no explanation of how the injury occurred;</p> <p>-The injury was called an injury with a mechanical lift because the resident said it happened during the transfer, although the resident could not say how it occurred exactly and the CNAs denied any action occurred to cause injury;</p> <p>-She did not feel any corrective measures or interventions were necessary since the CNAs were unaware of how the injury could have occurred and it was unintentional;</p> <p>-She did not update the resident's plan of care to prevent further accidents.</p> <p>2. Review of Resident #2's nurse note, dated 11/20/24 at 6:26 P.M., showed LPN G wrote the resident was pushed into room in wheelchair and left medial (middle) foot was bumped against the transfer pole, assessment showed no tenderness, no bruising or swelling was present and the resident was not complaining of pain. The primary care physician (PCP) and family were made aware.</p> <p>Review of the resident's Miscellaneous Event report, dated 11/20/24 at 6:46 P.M., showed:</p> <p>-Description: Left foot bumped on transfer pole;</p> <p>-No injury noted;</p> <p>-Evaluation note: the resident was being transferred in the lift when his/her leg was bumped on the wall., No injury noted. Monitored for 72 hours with no concerns.</p> <p>Review of the resident's care plan, dated 1/2/25, showed:</p> <p>-Problem: The resident was at risk for discomfort related to diagnosis of chronic pain syndrome; Interventions included: The resident was in a mechanical lift when it tilted his/her body when lowering him/her to the bed and the resident said it caused pain to his/her shoulder. No injuries were noted and the next day the resident said his/her shoulder was fine. The resident was non-compliant with care and moves unsafely in the mechanical lift. Multiple staff members go into the room when transferring the resident to keep him/her safe; Assess level of pain and provide comfort measures;</p> <p>-Problem: The resident was at risk for falls related to impaired mobility and weakness. Interventions included: The resident was lowered to the floor after the mechanical lift being used started to tilt. Employees lowered the lift down to the floor and reconnected to another lift to place the resident into his/her chair. The resident had a small bruise to his/her right cheek. Two employees were present during transfer;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Problem: The resident requires care in pairs with ADL assistance due to history of embellished stories; Interventions included: Direct care staff may pair two staff members together when providing care;</p> <p>-There was no documentation the resident required a Hoyer lift for transfers.</p> <p>Review of the resident's annual MDS, dated [DATE], showed:</p> <p>-Cognitively intact;</p> <p>-No behaviors noted;</p> <p>-Dependent on staff members' assistance for toileting, showers, lower body dressing and transfers;</p> <p>-Height of 66 inches and weight of 287 lbs;</p> <p>-Diagnoses included atrial fibrillation (irregular heart rate), heart failure, anxiety, morbid obesity and polyneuropathy.</p> <p>Review of the resident's nurse progress note, dated 1/29/25 at 9:53 P.M., showed LPN G wrote an aide informed him/her that during a transfer with a Hoyer lift with two aides, the resident was hit with the hook on the Hoyer lift. The resident said the Hoyer hook hit his/her right temple; on assessment no bruising or swelling was noted. Neuro checks were within normal limits and the resident denied pain. The PCP and resident's responsible party (RRP) was notified.</p> <p>Review of the resident's Miscellaneous Event report, dated 1/29/25 at 10:05 P.M., showed:</p> <p>-Description: The resident was hit with Hoyer hooks to the right temple with no injury;</p> <p>-Neurological check (neuro-checks, an assessment completed by nursing staff to monitor for changes in the resident's neurological (nervous system) status) were started;</p> <p>-Evaluation notes: Event still open.</p> <p>During an interview on 2/4/25 at 10:39 A.M., LPN G said:</p> <p>-He/She did not remember an incident, on 11/20/24, involving the resident getting his/her foot bumped during a Hoyer transfer;</p> <p>-On 1/29/25, he/she was the nurse assigned to the resident when the resident was struck in the face by the lift bar during a Hoyer transfer;</p> <p>-He/She was alerted by a CNA (unknown) that the resident was struck by the lift bar during a Hoyer transfer;</p> <p>-He/She went and assessed the resident, who confirmed he/she was hit in the right side of his/her temple by the metal lift bar;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident did not have any bruising, swelling, and did not complain of pain to his/her right temple;</p> <p>-The nurse completed a neuro-check and found the resident was within his/her normal limits, called the PCP and RRP;</p> <p>-The nurse then completed an event report in the resident's EMR with the PCP's new orders to monitor the resident's neurological status for 72 hours;</p> <p>-The nurse started the neurological checks and passed on in report to the next nurse;</p> <p>-The DON asked the nurse the next day about what happened;</p> <p>-The DON did not instruct the nurse to make any changes to the resident's plan of care;</p> <p>-He/She had not received any in-services on Mechanical Lift Policy in the last year;</p> <p>-He/She expected CNAs to transfer resident's safely while using a Hoyer lift by always having two staff present, one to work the machine and the other to guide the resident in the sling to prevent injury.</p> <p>During an interview on 2/4/25, at 12:51 P.M., the resident said:</p> <p>-Last week, he/she was hit in the head with the lift arm during a Hoyer transfer. The CNAs jerked the strap of the sling off of the lift arm so hard, it smacked the resident in his/her right temple;</p> <p>-The resident had neuropathy in his/her legs which made them very sensitive and painful;</p> <p>-He/She did not feel safe when CNAs transferred him/her with the Hoyer lift;</p> <p>-CNAs did not listen to the resident during transfers, ignoring the resident's pleas to be careful when moving his/her legs, to make sure he/she does not bump into objects while up in the sling;</p> <p>-When the resident was up in the Hoyer lift, he/she would swing without any support and hit his/her legs and feet against the wall;</p> <p>-The CNAs would say they were doing the best they could when the resident said they were hurting him/her and would continue with their task;</p> <p>-The resident would remind the CNAs to be careful with his/her left shoulder, as it was always in pain, when removing the sling from the lift bar;</p> <p>-The CNAs would jerk the sling off of the lift bar causing the resident to fall back into his/her wheelchair or bed, causing him/her pain;</p> <p>-There have been several near misses with the lift bar because the CNAs would not hold it still when they attached or removed the sling from it, causing the lift bar to swing back and forth in front of the resident's face;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2025
NAME OF PROVIDER OR SUPPLIER Delmar Gardens of Creve Coeur		STREET ADDRESS, CITY, STATE, ZIP CODE 850 Country Manor Lane Creve Coeur, MO 63141	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-There were some CNAs who were very kind and listened to the resident but most of them acted so angry and worked hastily;</p> <p>-The resident feared retribution from staff if he/she complained about the treatment and the fear he/she has when up in the Hoyer lift during transfers;</p> <p>-He/She did not feel that his/her concerns or complaints were taken seriously;</p> <p>-During the interview the resident was often tearful and whispered because he/she was afraid others might hear him/her.</p> <p>During an interview on 2/4/25 at 10:52 A.M., the DON said:</p> <p>-She did not recall an event on 11/20/24 involving the resident and a Hoyer lift transfer;</p> <p>-The facility did not investigate the event on 11/20/24;</p> <p>-She was not aware of the event that occurred on 1/29/25 and had not started investigation on the event;</p> <p>-She expected staff to report any accidents to her so she could conduct an investigation;</p> <p>-Nurses were not expected to report all events to the DON as nursing staff were able to take care of them independently;</p> <p>-She was responsible for reviewing events daily or at least every couple of days;</p> <p>-Staff conducted an improper Hoyer transfer if a resident was struck in the face by the metal arms of the cradle when staff removed the sling from the hook;</p> <p>-Staff conducted an improper Hoyer transfer if the resident's foot bumped into an object, causing them pain, due to staff not guiding the resident to prevent injury;</p> <p>-She did not update the resident's plan of care to prevent further accidents.</p> <p>3. During an interview on 1/31/25 at 11:36 A.M., LPN E said:</p> <p>-When a resident had a fall, an accident or injury of unknown origin, nurses were responsible for assessing the resident for injury or any change of condition, notify the PCP for any new orders, notify the RRP, list what interventions were tried or put in place, and the plan of care going forward. All of that information was then documented on an event note found in the resident's electronic medical record (EMR);</p> <p>-Nurses would try to find out what caused the fall, accident or injury of unknown injury by talking to their staff;</p> <p>-Neglect was defined as any time a staff member did not care for a residents' needs, by ignoring them or acting carelessly, causing the residents harm;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Nurses were expected to report any suspicion of abuse or neglect to their supervisor. Supervisors were expected to then investigate the incident by interviewing all residents and/or staff involved and making report to the appropriate agencies.</p> <p>During an interview on 2/4/25 at 10:27 A.M., LPN F said:</p> <p>-Nursing staff were expected to always use two people during a Hoyer Lift, one to operate the machine and the other to guide the resident to make sure the resident was safe and did not bump into any surfaces;</p> <p>-He/She would report to a Supervisor if a resident had an injury due to an unsafe transfer so they could investigate the incident.</p> <p>During an interview on 2/4/25 at 10:52 A.M., the DON said:</p> <p>-She expected nursing staff to have knowledge of and to follow facility policies;</p> <p>-An incident or accident was defined as a fall, an injury to the skin, anything that changed the condition of the resident unexpectedly;</p> <p>-An incident or accident also included events where staff caused harm or injury to the resident due to not following facility policies or professional standards of care;</p> <p>-She expected nurses to complete an event report in residents' EMR for any incident that changed the condition of the resident;</p> <p>-The facility would investigate events by interviewing staff and residents to see what occurred and based on what was found would provide in-services to staff to address the issue;</p> <p>-If staff conducted a transfer incorrectly, she would write-up the staff involved and provide education and counseling;</p> <p>-If staff conducted a transfer incorrectly that caused injury to a resident, she would suspend the staff involved pending investigation;</p> <p>-In-services to staff were started right after the event occurred, provided by the DON or the Assistant Director of Nursing (ADON);</p> <p>-Staff were expected to retain the education they received during in-services;</p> <p>-In-services were based on professional standards of care and facility policies;</p> <p>-If there was a pattern of the same type of accidents occurring again and again, she would do more in-services to staff and try to find out why the issue was still occurring;</p> <p>-She was not aware of any improper Hoyer transfers in her facility;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-A proper Hoyer transfer consisted of two staff members, one to control machine, the other to spot the resident for safety and to keep the Hoyer legs open for stability;</p> <p>-She recently gave nursing staff education on Hoyer lift transfers as part of a mock survey and had not completed it as of time of interview;</p> <p>-She did not recognize a pattern of improper mechanical lifts in the facility.</p> <p>MO00248154</p> <p>MO00243707</p>		