STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265711	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens of Meramec Valley	#1 Arbor Terrace Fenton, MO 63026

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow acceptable infection control standards by not implementing Contact Precautions (CP, precautions that reduce the risk of transmission of infectious materials by direct contact.) for one resident (Resident #19), failed to implement Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities) as recommended by the Centers for Disease Control and Prevention (CDC) and required by the Centers for Medicare and Medicaid Services (CMS) for four of 30 sampled residents (Residents #2, #3, #71, and #179), and failed to ensure hand hygiene was performed by staff while feeding a resident (Resident #146). The census was 153. Review of the Centers for Disease Control and Prevention guidelines, dated 4/2/24, showed:-The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization.-Examples of high-contact resident care activities requiring gown and glove use for EBP include: Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line (central venous catheter inserted into a large vein near the heart to administer medication, fluids, and draw blood), urinary catheter (external or internal urine collection device), feeding tube (a tube surgically inserted into the stomach to provide hydration, nutrition, and medication), and wound care: any skin opening requiring a dressing;-Contact Precautions require the use of gown and gloves on every entry into a resident's room. The resident is given dedicated equipment (e.g., stethoscope and blood pressure cuff) and is placed into a private room. When private rooms are not available, some residents (e.g., residents with the same pathogens) may be cohorted, or grouped together. Residents on contact precautions should be restricted to their rooms except for medically necessary care and restricted from participation in group activities. Review of the facility's infection control policy and procedure manual, dated 3/2020, showed:-Purpose: The community has established and maintains an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections;- EBP are indicated for residents with any of the following: Infection or colonization with a CDC-targeted MDRO when contact precautions do not otherwise apply; or wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO;-Personal Protective Equipment (PPE), gown and gloves, should be worn with during high-contact resident care activities: dressing, bathing/showering, transferring (not needed when transferring in common areas), providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, and wound care: chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage or similar dressing;-Contact Precautions: Wear clean gloves when entering the resident's room or unit if a multi bedroom. Wear a gown when entering resident area if you anticipate that you will have substantial contact with the resident, resident items, (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or environmental surfaces or if the resident is incontinent. Remove gown carefully before leaving the room and wash hands. During care, change gloves after having contact with infective material (e.g., fecal material or wound drainage which may contain high concentrations of microorganisms). Change gloves when moving from one site to another (i.e., oral care, dressing change). 1. Review of Resident #19's care plan, in use at the time of survey, showed:Problem: The resident is at risk for developing clostridium difficile (c-diff, bacteria in the gut that causes severe diarrhea);Approach: Follow infection control policies. Review of the resident's physician orders dated 12/1/25, showed an order, dated 11/21/25, droplet precautions (infection control measures to stop the spread of respiratory infections) for c-diff, no stop date. Observation and interview on 12/1/25 at 9:04 A.M., showed the outside of the resident's door had an EBP sign. Certified Nurse's Aide (CNA) C and CNA D were outside the resident's room and donned (placed on) isolation gowns and gloves. CNA D said the resident was on contact precautions for C-diff. The resident lay in bed and CNA C and CNA D assisted the resident with changing his/her brief. CNA C and CNA D turned the resident side to side and placed a Hoyer (a specialized lift) pad underneath the resident. CNA C and CNA D, with the same gloved hands, adjusted their isolation gowns by pulling them up, touching their uniform tops and attempting to re-tie the neck portion of the isolation gown. The resident was transferred to the Broda chair (a specialized reclining chair) with the use of the Hoyer lift. CNA C removed his/her gloves and said his/her hands were sweaty. CNA C then removed the resident's linen off of the bed with ungloved hands and placed them in a clear trash bag and removed them out of the resident's room and placed them in a laundry hamper located in the hallway.During an interview on 12/3/25 at 6:25 A.M., Laundry Assistant E said no resident has been on c-diff contact precautions in the last two to three weeks. The nursing staff should be using red bio-hazard bags for residents that are on contact precautions for c-diff to collect the resident's laundry so that the laundry department can make sure the laundry is washed separately.During an interview on 12/5/25 at 8:20 A.M., Certified Medicine Technician (CMT) O said if a resident has c-diff then a contact precaution sign should be on the door, not an EBP sign. Staff wear gown and gloves for contact precautions, and the resident's laundry and linens should be placed in a red bag and washed separate from other resident's laundry.During an interview on 12/5/25 at 8:32 A.M., Registered Nurse (RN) A said the resident was not on EBP or droplet precautions but was on contact precautions for c-diff, and those precautions were discontinued on 12/2/25. Staff should not be readjusting their isolation gowns after touching the resident. The staff are expected to wear gloves when handling the resident's laundry and linen and should be placed in a red bio-hazard bag. C-diff is highly contagious.During an interview on 12/5/25 at 10:44 P.M., the Infection Preventionist (IP) said she would expect staff to properly wear the isolation gowns and not readjust during care. She would expect staff to wear gloves when handling resident's laundry and collect the laundry in a bag and leave in the resident's room when the resident is on contact precautions. She would expect proper signage on the door for the specific isolation the resident is on so that staff and visitors are aware. During an interview on 12/5/25 at 11:24 A.M., the Director of Nursing (DON) would expect staff to follow the proper infection control prevention measures for residents who are on contact precautions for c-diff. She would expect the physician orders to for the specific isolation to be accurate. 2. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/19/25, showed:-Diagnoses: Diabetes, vascular dementia, and presence of a gastrostomy (feeding tube, g-tube); -Severe cognitive impairment. Review of the resident's care plan, in use at the time of the investigation, showed: -Problem: Resident is at risk for contracting an MDRO due to feeding tube that requires the use of PPE during high contact activities;-Goal: Resident's risk for contracting an MDRO will be decreased thru next review;-Approach: Resident is on EBP. Staff must perform hand hygiene before andafter providing care. Staff to wear gloves and gowns when providing high contact activities. Review of the resident's physician orders summary (POS), dated 12/2025, showed:-An order, dated 9/30/25, EBP: wear gloves and gowns for all high contact task, wear eye protection if splash anticipated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/5/25 at 8:04 A.M., showed RN N walk into the resident's room with his/her nursing cart to the resident's bed where the resident was lying in bed. RN N put on gloves without a gown. He/She lifted the resident's hospital gown, exposing his/her g-tube site while leaning against the resident's bed. He/She took off the resident's g-tube dressing, cleaned the area, and placed a new dressing. 3. Review of Resident #3's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Receives dialysis (an invasive procedure that cleanses the blood of its toxins). Review of the resident's care plan in use at the time of survey, showed:Problem: The resident is at high risk for developing multi-drug resistant organism due to dialysis port that requires the use of personal protective equipment during high contact activities;Approach: The resident is on EBP; Staff must perform hand hygiene before and after providing care;Staff is to wear gown and gloves when providing high contact activities. Review of the resident's POS dated 12/1/25, showed:-An order, dated 6/13/25, check dialysis port for redness, tenderness or breakdown, every shift;-An order, dated 6/13/25, EBP, wear gown and gloves for all high contact activities. Observation on 12/3/25 at 6:40 A.M., showed an EBP sign was not posted on the outside of the resident's room. CNA G entered the resident's room, performed hand hygiene and applied gloves. The resident lay in bed and requested to go to the bathroom. CNA G applied lotion to the resident's legs and applied the resident's right prosthetic (false) leg to the resident's right leg stump. CNA H entered the room and performed hand hygiene and applied gloves. CNA G and CNA H assisted the resident with stand by assistance, by applying a gait belt and positioning the walker in front of the resident. A dialysis port was present to the resident's right chest. The resident then ambulated into the bathroom. CNA G and CNA H did not wear an isolation gown while providing direct care. During an interview on 12/5/25 at 8:32 A.M., RN A said he/she didn't think that the resident needed to be on EBP due to his/her dialysis port because the nursing staff at the facility does not access the port. During an interview on 12/5/25 at 10:44 A.M., the IP said she would expect staff to wear a gown and gloves when providing direct care to the resident because the resident has a dialysis port. She would expect an EBP sign or magnet to posted outside of the resident's room. During an interview on 12/5/25 at 11:24 A.M., the DON said she expects staff to wear a gown and gloves when providing care to the resident due to the resident's dialysis port. The resident should have had an EBP sign posted on the outside of his/her room. 4. Review of Resident #71's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Used a Foley catheter;-Received routine wound care. Review of the care plan, revised 11/7/25, showed:-Problem start date: 6/5/24: Infection. The resident is at risk for contracting an MDRO due to an indwelling catheter that requires the use of PPE during high contact activities;-Goal: The risk of contracting MDRO will be reduced;-Approach: The resident is on EBP, staff perform hand hygiene before and after care. Staff to wear gloves and gowns when providing care. Discontinue EBP once wounds are healed or the indwelling device is discontinued. Review of the resident's POS, showed:-An order, dated 6/5/24: EBP- wear gloves and gowns for all high contact tasks and wear eye protection for splashing. Discontinue the order when the wound is healed or medical device has been removed;-An order, for daily Foley catheter care;-An order, for wound care every three days. Observation and interview on 12/1/25 at 8:12 A.M., showed an EBP magnetic sign on the resident's metal door frame. The sign showed EBP steps: Perform hand hygiene, wear a gown and gloves, dispose of gown and gloves in room and perform hand hygiene. PPE supplies hung on the bathroom door, which included gowns, gloves and masks. Resident #71 said he/she had wounds and a Foley catheter. Staff wear gloves to provide care and usually do not wear any additional equipment. Observation and interview on 12/3/25 at 8:46 A.M., showed CNA F said the resident had a Foley catheter and wounds to both feet. CNA F entered the resident's room and explained care to resident. CNA F did not perform hand hygiene before he/she applied gloves. CNA F said he/she was going to provide peri care (incontinence care) to the resident and give the resident a bed bath. CNA F did not apply a gown. He/She unfasted the resident's brief and turned the resident onto his/her side and provided peri-care. CNA F covered the resident with a blanket, removed his/her gloves, exited the room and returned with additional linens (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and placed the linens on the over bed table. CNA F did not wash his/her hands before applying gloves, and then filled a bath basin with water. CNA F did not apply a gown prior to care. During an interview on 12/3/25 at 9:22 A.M. CNA F said he/she had been in hurry to provide the bed bath to the resident. The resident had foot wounds and a Foley catheter in place. CNA F verified the resident was placed on EBP for high contact care duties. He/She did not look at the magnetic sign on the door frame and did not notice the PPE that hung in the room. Residents who have wounds and catheters are at risk for infection and staff should wear the PPE in the room when care is provided. 5. Review of the Resident #179's care plan, in use at the time of survey, showed:-Problem: The resident has an indwelling urinary catheter;-Approach: EBP related to the resident's urinary catheter was not addressed. Review of the residents POS, dated 12/3/25 showed:-An order dated, 11/28/25, implement EBP for high contact care. Observation on 12/2/25 at 4:05 P.M., showed an EBP sign was not posted on the outside of the resident's room. CNA I entered the resident's room, performed hand hygiene and applied gloves. CNA I propelled the resident from the bathroom to the resident bedside. The resident was holding his/her urinary catheter in his/her lap. CNA I removed the resident's urinary bag from the resident's lap and attached it under the resident's wheelchair. The resident requested to be covered. CNA I removed a blanket off of the resident's bed and positioned the blanket on the resident's lap. CNA I did not wear an isolation gown while providing direct care to the resident. During an interview on 12/5/25 at 8:32 A.M., RN A said the resident should be on EBP related to his/her urinary catheter and a sign for EBP should be posted. Nursing staff should be wearing gown and gloves when providing care to the resident. During an interview on 12/5/25 at 10:44 A.M., the IP said she would expect staff to wea a gown and gloves when proving care to the resident due to the resident's urinary catheter. The resident should have a EBP sign posted on the outside oh his/her room. During an interview on 12/5/25 at 11:24 A.M., the DON expects staff to wear a gown and gloves when providing care to the resident due to the resident's urinary catheter. The resident should have had a EBP sign posted on the outside of his/her room. 6. Review of Resident #146's medical record, showed:-re-admitted : 3/6/24;-Received hospice services;-Diagnoses included: Parkinson's disease (a movement disorder of the nervous system), dementia, anxiety, heart disease and stroke. Observation on 12/1/25 at 8:29 A.M., showed the resident in the dining room for the breakfast meal. Hospice CNA J sat next to the resident and assisted him/her to eat. Hospice CNA J used his/her bare hand to feed the resident a piece of bacon. During an interview on 12/1/25 at 9:01 A.M., the hospice CNA J said he/she had assisted the resident to consume breakfast. He/She used his/her bare hand to feed the resident a piece of bacon. He/She had forgotten to apply gloves before touching the bacon. He/She could have used utensils to assist the resident for his/her meal. Using bare hands increased the resident getting sick. 7. During an interview on 12/5/25 at 10:44 A.M., the IP said residents who have draining wounds, intravenous lines, drains and dialysis access should be ordered to receive EBP. Magnetic EBP signs are placed on the resident's door frame to notify staff of what kind of PPE should be worn with close contact care. PPE is placed in or directly outside of the resident's room. Staff should always wash hands before and after resident care. Facility staff and outside providers should never use bare hands to feed a resident; staff should use silverware or wear a glove. EBP should be worn when transferring, toileting, any physical contact with the resident and touching or handling medical equipment attached to the resident. 8. During an interview on 12/5/25 at 11:23 A.M., the DON said staff and outside providers should observe and follow the EBP posted on the resident's door frame and use the provided PPE to prevent the spread of infection. Using bare hands to assist a resident to eat increases the risk of infection. Staff should use gloves or utensils to assist residents to eat.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review, the facility failed to ensure respiratory services were provided consistent with professional standards of practice when staff administered a nebulizer (a medical device that administers breathing medication in an aerosol form) treatment to a resident without monitoring the resident during the treatment. In addition, the nebulizer face mask was not cleaned and stored properly after use for one resident (Resident #151). The sample was 30. The census was 153.Review of the facility's Nebulizer policy, last revised 5/2021, showed:-Purpose: To deliver prescribed medication deeply into the pulmonary (lung) airways;-Procedure: Check the physician orders for treatment specifications. Assemble equipment at bedside: Explain the procedure to the resident. Instruct the resident to sit up straight as possible. Instruct the resident to inhale deeply and hold for several seconds before exhaling. Take time to watch and coach the resident. If the resident does not breathe properly, the medication may not distribute evenly. When the treatment is completed, clean the nebulizer mask with water and air dry. Place equipment on a clean field such as a paper towel and place tubing is an unzipped Ziplock bag. Review of the facility's Nebulizer Cleaning policy, revised, May 2021, showed:-Purpose: To prevent contamination between uses;-Procedure: Check nebulizer medication chamber and mask prior to treatment to assure that it is clean and dry. After the pulmonary treatment, cleanse the medication chamber and mask with running water. Place chamber and mask on a clean paper towel to air dry. Store tubing in unzipped Ziplock bag or breathable bag. After cleansing, wipe off excess water with a paper towel and allow equipment to airy dry by setting on paper towel or other type of barrier. Review of Resident #151's care plan, in use at the time of survey, showed:-Problem: Respiratory: The resident requires oxygen;-Administer oxygen as ordered by the physician;-Monitor and report signs of hypoxia (low oxygen level);-Monitor oxygen saturation as ordered by the physician. Review of the resident's medical record, showed:-Diagnosis that included pneumonia (lung infection);-An order, dated 10/28/25, for ipratropium-albuterol (medication used to treat asthma) solution for nebulization 3 milters (ml); give every six hours only while the resident is awake. During an interview on 12/1/25 at approximately 10:00A.M., the resident said he/she receives respiratory treatment a couple of times a day because of his/her pneumonia. Observation showed the resident's nebulizer mask and tubing draped over the nebulizer machine on the resident's nightstand, uncovered. Observation on 12/2/25 at 11:17 A.M. and 11:38 A.M., showed the resident lay in bed on his/her right side with his/her eyes closed. The resident had a nebulizer mask positioned over his/her left cheek and eye. The nebulizer machine was on. At 11:40 A.M., the resident lay in bed on his/her left side with the nebulizer mask positioned on the resident's right cheek. The resident's eyes were closed. The nebulizer machine was on. At 11:45 A.M., the resident sat up at the bedside, the nebulizer machine was turned off, and the nebulizer mask was positioned on top of the nebulizer machine. Observation on 12/2/25 at 4:14 P.M., and 12/5/25 at 8:00 A.M., showed the resident's nebulizer mask was positioned on top of the resident's nightstand, uncovered. During an interview on 12/5/25 at 8:19 A.M., Certified Medication Technician (CMT) O said the resident has some confusion. The nebulizer treatments usually last about 10 or 15 minutes. CMT does not stay in the room with the resident during the whole treatment time and will occasionally check to make sure the treatment is still on the resident during that 10 to 15 minute time. The nebulizer breathing mask should be rinsed daily and stored in a Ziplock bag. The nebulizer mask and tubing are changed weekly. During an interview on 12/5/25 at 8:32 A.M., Register Nurse (RN) A said the CMT or nurse should stay in the room with the resident while the breathing treatment is being administered to ensure the resident has it on and to coach the resident to deep breathe during the treatment. The breathing treatment should not be given to the resident if he/she is sleeping. The nebulizer mask should be rinsed after every treatment and air dried on a paper towel. Once the nebulizer mask is dry the mask should be stored in a Ziplock bag. During an interview on 12/5/25 at 11:24 A.M., the Director of Nursing said the nebulizer breathing treatments only last 10 minutes and (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the staff are not expected to stay in the room with the resident. Breathing treatments are not to be administered if the resident is not actively awake and able to take in deep breaths to inhale the medication. The nebulizer mask should be rinsed after each use and air dried on a paper towel. The mask should be stored in a Ziplock bag once it is dry.