

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265792	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2024
NAME OF PROVIDER OR SUPPLIER Delmar Gardens of O'Fallon		STREET ADDRESS, CITY, STATE, ZIP CODE 7068 South Outer 364 O Fallon, MO 63368	

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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34003</p> <p>Based on interview and record review, the facility failed to consistently follow their policy to complete skin assessments to identify areas of concern to ensure timely implementation of interventions and treatment for one sampled resident, (Resident #2) of six sampled residents. The facility census was 167.</p> <p>Review of the facility policy for Pressure Ulcer Care and Documentation dated 7/21 showed:</p> <p>-Purpose: To prevent pressure injuries and/or prevent deterioration of existing pressure injuries:</p> <p>-Causes in part: impaired circulation, wrinkles,lumps in bedding and chairs; fragile skin caused by the aging process, pressure on bony prominence for example heels;</p> <p>-Warning signs: observe daily for the following signs of potential pressure injury signs and report accordingly: redness or a darker, beeper bruise-like color, heat, tenderness, pain or discomfort, cracks in the skin, excessive dryness, sores, cuts or abrasion. Report any changes of condition to the charge nurse;</p> <p>-Prevention: frequent applications of lotion, or approved ointment to skin surfaces with special attention to pressure prone areas;</p> <p>-Frequent turning and/or repositioning no less than every two hours;</p> <p>-Use of anti-pressure devices: air mattress to bed, speciality mattress to bed, air cushion to wheelchair;</p> <p>-Straighten or tighten sheets and chair pads frequently;</p> <p>-Procedure: observe reddened or pressure injury prone areas; rub skin with lotion, or approved ointment; tighten linen (must be free from wrinkles; turn resident frequently; report any abnormalities to charge nurse;</p> <p>-Procedure for Stage I or greater pressure injuries: any time a Stage I or greater pressure ulcer is noticed on a resident the charge nurse must fill out a wound management assessment in the electronic medical record and report it:</p> <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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The charge nurse must notify physician of pressure injury for treatment orders. The resident representative is also notified;</p> <p>-Weekly wound assessments for each pressure ulcer must be completed;</p> <p>-The charge nurse must notify physician if not improvement occurs after two weeks of treatment.</p> <p>Review of the facility policy for Pressure Ulcer/Pressure injury (PU/PI) prevention policy dated 1/21 showed:</p> <p>-Purpose: to identify and determine those residents are risk for the development of PU/PI; to maintain resident skin integrity; to provide early detection of skin breakdown; and to promote timely evaluation and interventions of changes in resident's skin;</p> <p>-Definitions: PU/PI: localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device:</p> <p>Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum- filled blister.</p> <p>-Risk factors that predispose the resident to the development of PU/PI are, but are not limited to: impaired/decrease mobility and decrease functional ability; impaired diffuse or localized blood flow such as atherosclerosis (thickening or hardening of the arteries caused by a buildup of plaque in the inner lining of an artery), peripheral vascular disease (PVD-narrowing of peripheral blood vessels (vessels situated away from the heart or the brain) or lower extremity arterial insufficiency); immobility during hospitalization or surgical procedures prior to coming to the community; prolonged immobility following medical event or fall;</p> <p>-Procedure: all residents will assessed for PU/PI upon admission and quarterly using the Braden scale assessment (developed to foster early identification of patients at risk for forming pressure sores. The scale is composed of six subscales that reflect sensory perception, skin moisture, activity, mobility, friction and shear, and nutritional status);</p> <p>-Nurse aides (NA) will complete a bath sheet at the completion of each resident shower. The NA will indicate on the bath sheet if the skin is normal or abnormal. The charge nurse (CN) will assess any altered skin changes noted on the bath sheet by the NA. The nurse manager will review the bath sheets daily and follow up with CN if skin impairment is noted;In addition to looking at the resident's total Braden score to determine risk, nursing staff will evaluate what sub-category predisposes the resident for the development of a PU/PI;</p> <p>-CN will update care plan with interventions to prevent PU/PI at the time risk is identified;</p> <p>-Interventions to manage risk will be communicated to NA via Certified Nurse Aide (CNA) report sheet, electronic profile or CNA assignment sheet.</p> <p>1. Review of Resident #2's face sheet showed:</p> <p>-Initial admitted was 9/30/23;</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-discharged from the facility on 10/1/23 then readmitted on [DATE];</p> <p>-discharged from the facility on 11/13/23;</p> <p>-Diagnoses of sepsis (a serious condition in which the body responds improperly to an infection); intestinal obstruction with ostomy, weakness, diabetes with chronic diabetic kidney disease. heart failure, chronic obstructive pulmonary disease.</p> <p>Review of the nurses notes dated 9/30/23 showed no documentation of any skin issues.</p> <p>Review of the Treatment Administration Record (TAR) dated 9/30/23 showed skin intact with no issues.</p> <p>Review of the resident's plan for skin dated 10/1/23 showed the following:</p> <p>-The resident is at risk for skin breakdown related to limited mobility related to generalized weakened state;</p> <p>-Goal: Resident's skin will remain intact;</p> <p>-Assess resident for presence of risk factors. Treat, reduce, eliminate risk factors to extent possible; conduct systematic skin inspection per orders keep lean and dry, report any signs of skin breakdown (sore, tender, red, or broken areas).</p> <p>Review of the resident's Braden Scale (a tool used to evaluate a resident's risk for skin breakdown), completed on 10/1/24 showed a score of 14, at moderate risk for skin breakdown.</p> <p>Review of the resident's TAR dated 10/1/23 through 10/09/24 showed:</p> <p>-No skin assessment documented for 10/1/23;</p> <p>-Hospital marked on 10/2/23;</p> <p>-No documentation from 10/3/23 10/8/23;</p> <p>-Resident readmitted to the facility on [DATE] with no documentation staff completed a skin assessment at the time of the resident's readmission.</p> <p>Review of the resident's admission Minimum Data Set, (MD'S) a federally mandated assessment instrument completed by facility staff, dated 10/18/23 showed:</p> <p>-Usually able to make self understood and sometimes understands others;</p> <p>-Alert and oriented and able to make decisions;</p> <p>-Dependent upon staff for mobility and repositioning;</p> <p>-At risk for the development of PU/PI, no PU/PI.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's TAR dated 10/09/23 through 10/31/24 showed the following:</p> <ul style="list-style-type: none"> -No documentation of a skin assessment completed 10/9/23 through 10/15/23; -On 10/16/23 and 10/23/23, skin intact marked yes with no abnormal skin noted; -Order for skin prep wipes to left inner heel ordered on 10/27/23; -On 10/30/23 marked not done - resident not available. <p>Review of the resident's nurses notes dated 10/18/23 through 11/3/23 showed no documentation of any PU/PI or skin issues. There was no documentation for the order of skin prep to the left heel on 10/27/23.</p> <p>Review of the resident's weekly skin assessment dated [DATE] through 11/30/23 showed no skin assessment documented 11/1/23 through 11/4/23.</p> <p>Review of the nurses notes dated 11/04/23 at 9:59 P.M. showed:</p> <ul style="list-style-type: none"> -Blister to right heel found open and skin flap loose, 4.5 cm x 4.5 cm cleansed with normal saline, applied triple antibiotic ointment (TAO) and covered with ABD (wound dressing) and gauze. <p>Review of the resident's TAR for the weekly skin assessment dated [DATE] showed open blister to left heel.</p> <p>Review of the nurses notes dated 11/8/23 through 11/13/23 showed no documentation of the resident's skin for either the right or left heel.</p> <p>During an interview on 3/22/24 at 4:00 P.M. the resident's Family Member A said the following:</p> <ul style="list-style-type: none"> -Resident #2 had been complaining about his/her right heel hurting for several weeks before the facility began treating it; -The resident had been receiving a treatment to the left heel and ankle area due to an injury that occurred during a transfer, there was no open area on the left heel; -When the resident came back from the hospital on 10/9/23, he/she had a large fluid filled blister on the inner aspect of the right heel; -He/She told the staff about it, but no one was doing any treatments to the heel; -The blister opened up on 10/26/23 and he/she and the resident had asked for a treatment to be done, but no one did anything until 11/4/23; -The open area was about the size of a nickel and was deep; -The resident went home and recieved services from a wound clinic. <p>(continued on next page)</p>		

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