STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265792	A. BUILDING _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF O'FALLON	7068 SOUTH OUTER 364 O FALLON, MO 63368

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to safely transfer one resident (Resident #1), in a review of two sampled residents who transferred with a sit-to-stand lift. Staff identified Resident #1 was fatigued in the evening, and during transfer with the sit-to-stand lift, the resident's legs would not support his/her weight sufficiently. On the evening of 03/05/25, staff transported the resident in a sit-to-stand lift from his/her bathroom to his/her bed. Staff reported the resident's legs began to give way and the resident began to slide out of the lift sling (a sling that was positioned around the resident's back and under his/her arms), during a transport in the lift from the toilet to the bed. Staff rushed the resident to the bed while in the lift to prevent him/her from falling out of the sling. The resident sustained a significant injury to his/her leg which required surgical repair. Staff failed to properly transfer the resident per the manufacturer's user manual which specifically stated the sit-to-stand lift was not a transport device and was intended for transfers from one seated surface to another. The facility's census was 150. Review of the facility's policy for transferring a	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Teresa L. Ritter | TITLE: Administrator | (X6) DATE: 4-10-25

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.

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F 689	Continued From page 1	F 689		

resident via a sit-to-stand mechanical lift, last reviewed August 2024, showed the following:
-Purpose was to enable staff to safely transfer residents using a sit-to-stand mechanical lift;
-Always refer to the manufacturer's instruction;
-The resident must be able to support the majority of their own weight (if unable, refer to therapy for further instructions);
-Place sling to the lower back of the resident with their arms outside of the sling per manufacturer's recommendations.

Review of the user manual for the Stand-Up Patient Lift RPS350-2, dated December 2013, showed the following:
-Do not use this product without first completely reading and understanding these instructions;
-This patient lift is NOT a transport device. It is intended to transfer an individual from one seated surface to another;
-Stand Assist Slings: Before lifting the patient, make sure the bottom edge of the stand assist sling is positioned on the patient's lower back and the patient's arms are outside the stand assist sling;
-DO NOT use the stand assist sling in combination with the patient lift as a transport device. It is intended to transfer an individual from one resting surface to another.

1. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility, dated 02/07/25, showed the following:
-He/She admitted to the facility on 02/04/25;
-Diagnoses included arthritis, osteoporosis (a condition that weakens bones, making them fragile and prone to fractures, often developing silently until a fracture occurs), malnutrition, and

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F 689	Continued From page 2	F 689		

dementia;
-His/Her cognition was severely impaired;
-He/She was 64 inches tall and weighed 189 pounds;
-He/She was dependent on staff for position changes from sitting to standing;
-He/She was dependent on staff for chair/bed to chair transfers;
-He/She was dependent on staff for transferring to the toilet;
-Ambulation was not attempted.

Review of the resident's physician's orders, dated 02/04/25, showed the resident was a two person transfer.

Review of the resident's care plan, dated 02/05/25, showed the following:
-The resident had a deficit in mobility related to weakness. Weight bearing as tolerated (WBAT) two-person transfer;
-Transfer status changed to a two person assist with a sit-to-stand lift (02/05/25).

Review of the resident's Physician Orders, dated February 2025, showed the following:
-An order dated 02/07/25, directing two staff to transfer the resident with a sit-to-stand lift;
-An order dated 2/10/25 directing staff to transfer the resident with the Hoyer lift (mechanical lift used to transfer a person from one surface to another via use of a full body lift in a sling).

Review of the resident's care plan, dated 02/11/25, showed the resident had a deficit in mobility related to weakness. Transfer status changed to a two person assist with a Hoyer lift.

Review of the resident's physician's order, dated

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F 689	Continued From page 3	F 689		

02/14/25, showed the resident was to transfer with the sit-to-stand lift.

Review of the resident's care plan, dated 02/17/25, showed the resident's transfer status was changed to a two person transfer with sit-to-stand lift.

Review of the resident's physician's note, dated 02/25/25, showed the resident's primary diagnosis was generalized weakness.

Review of the resident's physical therapy encounter note, dated 02/28/25 at 4:53 P.M., showed Physical Therapy Assistant (PTA) F documented the following:
-Two person Hoyer lift transfer. Discussed and agreed to sit-to-stand lift;
-Sit to stand: not applicable;
-Chair/bed to chair transfer: not applicable;
-Balance on standing: not applicable;
-Response to treatment: The resident was unable to tolerate sit-to-stand transfer training due to complaints of increased soreness and swollen feet.

Review of the resident's hospice progress note, dated 03/01/25 at 7:16 P.M., showed the following:
-The resident transferred from the facility's rehabilitation unit to long-term care on 03/01/25;
-The resident was initially in the wheelchair during the visit, but he/she appeared very fatigued and agreed to go to bed;
-The resident had three plus edema (swelling with noticeably deep pit with the dependent extremity full and swollen that takes up to 30 seconds to rebound) of the lower extremities;
-Family reported resident complained of pain in

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the lower extremities and foot/toe fractures.

Review of the resident's progress note, dated 03/05/25 at 7:45 P.M., showed the following:
-The resident had a large skin tear to the posterior (back) left leg;
-Upon arrival to the resident's room, the resident was still connected to the sit-to-stand lift and he/she moaned in pain;
-There were puddles of blood on the sit to stand lift base;
-Assessment revealed a large amount of the resident's fat tissue hung from the left calf area of his/her leg;
-Skin tear was approximately 20 centimeters (cm) long, wide, and open with deep tissue injury noted;
-Certified nursing assistant (CNA) reported that while two staff were transferring the resident via the sit-to-stand lift to the bed, the resident's leg bumped into the metal rail on the side of the bed which caused the skin tear;
-The resident was sent to the hospital via emergency medical services (EMS).

Review of the facility's event report documentation for the resident, dated 03/05/25 at 10:39 P.M., showed the following:
-Date of event: 03/05/25 at 7:45 P.M.;
-Type of injury: approximately 20 centimeter (cm) deep laceration to the left lower extremity with a large amount of blood;
-Resident had severe horrible/intense amount of pain;
-Injury occurred during a transfer;
-Resident was sent to the hospital for evaluation and treatment of the lacerated extremity.

Review of the resident's hospital operative report,

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dated 03/06/25, showed the following:
-Preoperative diagnosis was left leg wound;
-Post operative diagnosis: 35 cm complex left leg wound;
-Crush injury to the left calf with a large skin flap opening measuring 35 cm. A drain was placed in the floor of the wound, and the skin edges were reapproximated with sutures and staples.

Observation of the resident's left posterior leg/calf on 03/11/25 at 1:15 P.M. showed a large, V-shaped laceration with sutures, staples, and a drain coming from the wound. The resident vocalized pain when the leg was moved.

Observation in the resident's room on 03/11/25 at 1:15 P.M., showed the resident's toilet was located in his/her bathroom that was separated from the resident's room by a doorway. The resident's bed was located across the room from the bathroom. In order to get to the bed from the bathroom toilet, staff and the resident had to travel through the bathroom doorway and across the room to the resident's bed.

During an interview on 03/11/25 at 3:50 P.M., CNA A said the following:
-He/She worked with the resident on the evening of 03/05/25;
-He/She and CNA B assisted the resident from the bathroom to the resident's bed via the sit-to-stand lift;
-As he/she pushed the resident in the lift from the toilet to the bed, the resident's legs began to buckle (give way) and he/she got the resident to the bed;
-As he/she lowered the resident to the bed, the resident yelled "My leg!", and that was when he/she noticed the blood and "skin flopping";

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F 689	Continued From page 6 -He/She did not understand what happened; -He/She was taught he/she could transport residents short distances such as from the bathroom, in the sit-to-stand lift; -The resident did not stand well with the transfer on 03/05/25 which was a short distance. During interviews on 03/11/25 at 4:00 P.M., 03/12/25 at 9:00 A.M., and 03/18/25 at 10:15 A.M., CNA B said the following: -He/She worked with CNA A on the evening of 03/05/25 and assisted with transferring the resident with the sit-to-stand lift to the bathroom and back to the bed; -As they transported the resident in the lift from the toilet to the bed, the resident's legs began to buckle. The resident was almost in a sitting position while attached to the sit-to-stand lift and started to fall out of the sling; -He/She grabbed onto the resident's incontinence brief because that was all he/she had to grab onto to keep the resident from falling out of the sling; -The resident needed to get to the bed quickly; -CNA A quickly pushed the resident in the lift to the bed; -He/She was not sure what happened to cause the injury, but assumed the force of hitting the bed caused the wound; -The resident's legs and feet were swollen prior to the incident; -He/She cared for the resident when the resident was on the rehabilitation unit (prior to 3/1/25); -He/She transferred the resident with the sit-to-stand lift one time when the resident was on the rehab unit and the resident's legs buckled during that transfer which caused him/her to have to hurry to get the resident transferred to avoid injury;	F 689		

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F 689	Continued From page 7 -He/She was upset about the resident's transfer status change from a Hoyer lift to a sit-to-stand lift and discussed his/her concerns with Licensed Practical Nurse (LPN) C (after he/she transferred the resident with the sit to stand lift while the resident resided on the rehabilitation unit); -The sit-to-stand had one sling which wrapped around the resident's back, under the arms, and buckled in the chest area;. During an interview on 03/12/25 at 9:20 A.M., LPN C said the following: -He/She was familiar with the resident; -The resident's transfer status had been a "roller coaster"; -At first, the resident required a Hoyer lift for transfers. The resident's transfer was changed to a sit-to-stand lift transfer which was successful for awhile, but later staff had to use the Hoyer lift in the evenings because the resident's legs would not hold him/her up due to a decline in his/her condition; -There was an incident while the resident resided on the rehabilitation unit where the CNAs tried to transfer the resident from his/her chair in the sit-to-stand lift. The resident's legs buckled when staff attempted to stand the resident in the lift. The staff had to lift the resident up from the chair enough to place a Hoyer lift pad under him/her and then proceeded to transfer the resident in the Hoyer lift because the resident could not tolerate the sit-to-stand; -The resident started to get weaker which was reported to the following shift and placed on the 24-hour report sheet, but he/she was not sure of an exact date that was completed; -The resident became weaker in the evening and nights.	F 689		

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F 689	Continued From page 8 During an interviews on 03/11/25 at 2:05 P.M. and 03/12/25 at 11:10 A.M., LPN D said the following: -He/She was familiar with the resident; -The resident transferred with a sit-to-stand lift and did okay most days, but his/her knees would buckle at times; -The resident had broken toes (as a result of a fall on 2/19/25), which could have affected the resident's ability to stand; -He/She was made aware of the resident's legs giving out, but did not witness the transfer. He/She was unsure who voiced concerns about the resident's transfer status; -If a CNA voiced concerns about a resident's ability to transfer, he/she would instruct that CNA to tell therapy and have therapy staff observe/evaluate the resident's transfer status; -Therapy gave all the recommendations for transfers, but staff could change to a higher level of transfer, such as from a sit to stand to a Hoyer, if there were safety concerns at that time and then communicate with therapy; -He/She worked on the rehab unit and would go directly to therapy and voice his/her concerns with a particular resident's situation. During an interview on 03/11/25 at 4:35 P.M., the Assistant Director of Nursing (ADON) said the following: -She investigated the incident involving the injury to the resident's left calf; -During transfer from the toilet to the resident's bed, the resident started to move into a sitting position while connected to the sit-to-stand lift; -The resident's legs were edematous and staff bumped the resident's leg on the bed; -Staff reported the resident's leg "exploded and opened";	F 689		

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F 689	Continued From page 9 -She had no prior knowledge of the resident's legs buckling during a sit-to-stand transfer. During an interview on 03/12/25 at 9:00 A.M., Physical Therapy Assistant (PTA) A said the following: -Therapy evaluated the resident. At first, the resident used a Hoyer lift for transfers, but later changed to a sit-to-stand; -The resident did not participate in therapy, discharged from therapy services (on 2/28/25), and moved to long-term care; -Staff could use a Hoyer lift if they felt the sit-to-stand transfer was unsafe for the resident, and then follow up with therapy for further evaluation; -He/She was never made aware of the resident's inability to use the sit-to-stand and/or that the resident's legs buckled during transfers. During an interview on 03/14/25 at 1:00 P.M., PTA F said the following: -The resident's transfer status was a sit-to-stand, but sometimes the resident required a Hoyer lift depending on how the resident felt; -The resident fatigued easily and could use the sit-to-stand if he/she was able to tolerate the lift. If the resident was fatigued, he/she required the Hoyer lift to transfer. This should have been documented on the resident's care plan; -On 03/05/25, staff should have had a wheelchair close by when transporting the resident in the lift from the bathroom toilet to the bed because the resident fatigued easily; -If the resident became fatigued and his/her legs began to buckle, staff could lower the resident to the wheelchair and transport to the resident to the bed in the wheelchair; -He/She had no prior knowledge of the resident's	F 689		

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legs buckling during a sit-to-stand transfer;
-If the resident was not on therapy, staff could have contacted therapy to evaluate the resident's transfer status;
-He/She reviewed the therapy discharge note and was unable to locate the resident's transfer status upon discharge from rehab services (on 2/28/25).

During an interview on 03/11/25 at 4:35 P.M. the Director of Nursing (DON) said the following:
-She felt as if the staff followed proper protocol and transfer technique per the resident's plan of care when they transported the resident in the sit-to-stand lift from the toilet to the bed;
-The ADON notified her that on 03/05/25, the resident's legs started to buckle during transport from the toilet to the bed;
-She had no prior knowledge of the resident's legs buckling during a sit-to-stand transfer;
-Nurses document any concerns, including therapy concerns, on the 24-hour report sheet. The 24-hour report sheet is turned in daily to administration and then disbursed to the individual department(s) with concerns such as therapy;
-Nursing staff are to complete a direct communication form and place it in a box at the nurse's station for therapy if there were any concerns with a transfer status.

MO 250720

Missouri Department of Health and Senior Services

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A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II Refer to F689.	A4075		

Missouri Department of Health and Senior Services

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Teresa K. Rutter — TITLE: Administrator — (X6) DATE: 4-10-25

PLAN OF CORRECTION

Provider/Supplier Name:	Delmar Gardens of O'Fallon
Street Address, City, Zip:	7068 South Outer Rd 364, O'Fallon MO 63368
Date of Survey:	3/19/25

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		
ID PREFIX TAG	**PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**	**COMPLETION DATE**
	This Plan of Correction is submitted as required under State and Federal law. The submission of the Plan does not constitute an admission on the part of Delmar Gardens of O'Fallon (the "Community") as to the accuracy of the surveyor's findings or the conclusions drawn there from. This Plan of Correction does not constitute an admission on the part of the Community that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied. Any change to Community policies and procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding State rules of civil procedure and should be inadmissible in any proceedings on that basis. The Community submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director or shareholder of the Community.	
F689	The facility will continue to ensure that resident environment remains as free of accident hazards as is possible and that residents are transferred in a safe manner. Resident #1 no longer resides in the Community. The Community does not agree with the Surveyor's findings. The Community respectfully requests an Informal Dispute Resolution to present evidence that the Community was transferring the resident in the safest manner and according to training guidance provided by the sit-to-stand manufacturer; Invacare.	4/14/25

Teresa L Lutz
Administrator
4-10-2025

	Pending the Informal Dispute Resolution, the Community has decided to remove the sit-to-stand devices from use at this time. All residents that utilize the sit-to-stand lift will be screened by Therapy. Recommendations will be made to the physician and their transfer orders will be adjusted accordingly. Nursing Staff will be re-educated on the use of "Stop and Watch" as a communication tool to be utilized when staff identify any concern related to resident transfers. DON/designee will audit all Stop and Watch forms for 12 weeks to observe for proper communication and follow-through on transfer related concerns. New employees will be educated on the Stop and Watch tool during orientation. Ongoing training will occur yearly and/or as needed. Compliance will be reported monthly to the Quality Assurance and Improvement Committee.	
A4075	Refer to F689	4/14/25

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.