STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4/29/25

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

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F 584	Continued From page 1 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a clean, comfortable, home-like environment when staff did not ensure one resident's (Resident #53's) shower drainage was properly maintained to allow water to flow unobstructed. The sample size was 35. The census was 181. Review of Resident #53's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/9/25, showed the following: -Diagnoses included dementia and chronic obstructive pulmonary disease (COPD, lung disease); -Shower/bathe self with Partial to moderate assistance. Review of the resident's care plan, dated 3/11/25, showed a deficit in mobility and activities of daily living (ADL) functions with COPD, dementia with cognitive impairment, and the need for occasional supervision and cueing with ADLs. Observation of the resident's shower on 4/7/25 at 2:39 P.M., showed the shower floor had a slight slope towards the drain which created a pool of water within 20 seconds during the water flow. Observation of the resident's shower on 4/8/25 at 1:55 P.M., showed the shower floor had a slight slope towards the drain which created a pool of water that measured 4 inches in dominator during the 1 minute and 2 second water flow duration.	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

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F 584	Continued From page 2	F 584		

Observation of the resident's shower on 4/9/25 at 7:41 A.M., showed the shower floor had a slight slope towards the drain which created a pool of water that measured 10 inches in diameter during the 2 minute water flow duration.

During an interview on 4/7/25 at 2:39 P.M., the resident said he/she had reported the issue to staff last week, but it was still not fixed. When he/she attempted to take a shower this morning, he/she could not wash his/her hair and only rinse off due to the amount of water that was backing up.

During an interview on 4/9/25 at 10:15 A.M., Certified Nursing Assistant (CNA) K said the resident made him/her aware of the water backup in the shower a few days ago but he/she could not remember the exact day. He/She immediately told Maintenance L when he/she walked past him/her in the hallway. He/She had no knowledge if the problem was fixed. The process in which staff inform the maintenance department of any issues is when maintenance passes them in the hallway, they let them know.

During an interview on 4/9/25 at 10:20 A.M., Maintenance L said he/she could not remember if he/she was made aware of the drain in the resident's shower, but he/she probably was and just forgot. He/She is generally made aware of any maintenance issues by the staff when he/she passes the staff in the hallway. Maintenance L is unaware of any maintenance log or any other type of maintenance request system to document maintenance needs.

During an interview on 4/9/25 at 9:40 A.M., Receptionist M said when he/she gets

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

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F 584	Continued From page 3 maintenance or housekeeping requests, it is recorded in the carbon copy call-log book. He/She then gives the top copy to the appropriate department. Receptionist M was unsure if all the other receptionists do the same. During an interview on 4/10/25 at 8:45 A.M., the Maintenance Director said he was unaware there was an issue in the resident's shower. The facility does not have a process to document maintenance concerns. Staff will tell maintenance in passing if they have concerns. It was not uncommon for things to be forgotten when they are reported maintenance as they are walking by to complete another task. However, requests are also sometimes given to the receptionist. He expected for the shower drain to have been unclogged the same day they were made aware of the issue.	F 584		
F 689 SS=D	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 maintain an environment free of accident hazards by not maintaining proper body mechanics while transferring a dependent resident (Resident #67). Two Certified Nursing Assistants (CNAs) placed a	F 689		

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	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

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F 689	Continued From page 4	F 689		

gait belt around Resident #67's abdomen loosely, and both CNAs placed their arms directly up and under resident's arm pits to lift the resident. One CNA grabbed his/her waistband to pull him/her to a standing position. The sample was 35. The census was 181.

Review of the facility's Gait belt policy, dated effective 7/2015, Reviewed 6/21, showed:
-Wrap gait belt around resident's waist and pull the strap through the buckle to tighten;
-4. Gait belt should be snug but not uncomfortable. Make sure you can slide your open flat hand between the belt and resident;
-6. Face resident when assisting resident with mobility by pulling on belt;
-9. Follow proper body mechanics when using gait belt and refer to transfer policy for proper transfer techniques.

Review of Resident #67's diagnoses, showed dementia, mood disturbance, anxiety, high blood pressure, type 2 diabetes mellitus with diabetic neuropathy-Polyneuropathy (with a decrease in nerve sensation), cervical disc degeneration (degeneration of the spine in the neck area), urinary incontinence, age-related physical debility, and repeated falls.

Review of the resident's admission Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 12/30/24, showed:
-Cognitively intact;
-Used a wheelchair;
-Range of motion coded no impairment

Review of the resident's physician orders, showed an order, dated 1/7/25, transfer order: x1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

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F 689	Continued From page 5	F 689		

assist.

Review of the resident's care plan, in use at the time of the survey, showed:
-Problem: At a risk for falls, due to dementia, high blood pressure and incontinence;
-Goal: Decrease the risk of falls and/or injury should a fall occur;
-Intervention: Assess for additional safety devices and ability to use call-light. Staff will also adjust environment low stimulation and free from clutter for increased confusion and poor vision;
-The care plan updated as of April 1, 2025, to show the residents recent decline in mental and physical status.

Observation on 4/8/25 at 8:04 A.M., showed CNA N entered the resident's room. CNA O also entered the resident's room. A CNA placed a gait belt above the resident's belly button but below the breast line loosely. His/Her wheelchair was positioned perpendicular to the bed. Both CNAs placed their forearms directly underneath his/her arm pits and lifted the resident to an upright stance. Resident # 67 was not given any warning, or verbal communication prior to the CNAs lifting him/her out of the wheelchair. Resident #67 had a tennis shoe on the right foot and a heel protective boot (heel float boot) on the left foot. During the transfer the resident's legs were in a locked position and the resident did not pivot his/her feet. When staff placed him/her in bed, his/her legs faced to the left, and his/her upper body leaned right in a twisted and unnatural body alignment.

During an interview on 4/9/25 at 11:38 A.M., Physical Therapy Assistant (PTA) F said he/she was involved with the resident's therapeutic needs regarding range of motion (ROM). He/she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

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F 689	Continued From page 6	F 689		

has worked with the resident approximately 7 times since the beginning of 2025. He/She acknowledges the resident's ability to use a sliding board for self-transfer with a CNA present. He/She is unaware what medical change occurred, but noticed a mentation change that included decline in physical stamina along with personality and assumed a urinary tract infection (UTI). PTA F recalls the resident falling and it physically took 3 staff members and the PTA assist to help Resident #67 into a chair. After that encounter, PTA F believes Resident #67 was sent to local hospital for an evaluation. Since his/her return from a week long hospitalization, no new orders or physical assessment was completed. Resident #67 remains a x1 assist.

During an interview on 4/8/25 at 10:30 A.M., the Director of Physical Therapy said she was unable to give specifics regarding Resident #67 and is unfamiliar with personalized care of residents at this time. On 4/9/25 at 11:30 A.M., the Director of Physical therapy said a resident who required a 2 person assist with a gait belt would present like this: a staff member would position the chair 45 degrees to one side of the bed. The gait belt would be positioned around the upper portion of the belly button but below the breast line. The safety device should appear snuggly, but not tightly. Both staff members need to be in ready motion, with a staff personnel standing in the front of the resident. Staff should have bent knees, providing verbal cues to the resident before the resident is in an upright stance. Personnel continues verbal commands to the resident until the transfer is completed. The resident's body would remain free from abnormal ligament, twisting motions or restricting devices limiting range of motions, which includes a heel float

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	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

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F 689	Continued From page 7 boot. During an interview on 4/10/25 at 1:50 P.M., the Director of Nursing (DON) said nursing staff should transfer residents according to facility policy. He/She confirmed the proper technique was to use a gait belt around the mid sections of the individual and have the belt snuggly, leaving enough space for the CNA's hand to slide comfortably between the resident and the belt. The belt is the only garment that should be held by the staff when transfers occur. Using an article of clothing, for example utilizing a fabric waist band, would be considered noncompliant with facility policy. Failure to follow policy could lead to harm to staff and ultimately the resident. It is essential for there to be verbal communication from staff to Resident #67 during the transfer. Failure to provide cues or step by step directions during the transfer can lead to confusion. A resident who is dependent on 2 staff assist is required to be able to pivot their own weight during the transfer. He/She could not see a safety concern with a resident being transferred with a heel protective boot on. The resident should be a mechanical lift if they cannot transfer themselves or a physical decline is noted. Resident #67 was noted to have a decline and is not fully back to baseline after readmission from the hospital.	F 689		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.	F 694		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

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F 694	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure intravenous (IV) services provided were consistent with professional standards of practice when a Licensed Practical Nurse (LPN) removed a peripherally inserted central catheter (PICC line, a thin, soft, long catheter (tube) that is inserted into a vein in the arm, leg or neck that is used for IV medications and fluids) for one resident (Residents #142). The sample was 35. The census was 181. Review of the Rules of Department of Commerce and Insurance, Division 2200-State Board of Nursing, Chapter 6-Intravenous Infusion Treatment Administration, dated 5/31/24, showed: -Definitions: Administer: to carry out comprehensive activities involved in IV infusion treatment modalities that include, but are not limited to, the following: observing; performing; monitoring; discontinuing; maintaining; regulating; adjusting; documenting; assessing; diagnosing; planning; intervening and evaluating; -Central venous catheter: a catheter that is advanced through the internal jugular vein (vein in the neck), cephalic (a superficial vein in the arm) or basilic vein(vein in the upper arm) in the antecubital fossa (front of the elbow, between the arm and forearm) or subclavian vein (vein under the collarbone), with the catheter tip terminating in the superior vena cava (a large vein that carries deoxygenated blood from the head, neck, arms, and upper chest back to the heart). Central venous catheters may be used to administer prescribed IV infusion treatments modalities or to perform prescribed IV infusion diagnostic procedures and include but not limited to PICC (line);	F 694		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 694	Continued From page 9	F 694		

-Graduate practical nurses, IV-certified LPN, and LPN nurse who hold an active multistate license to practice under the nurse licensure compact shall not, under any condition, perform the following functions or duties:
-Remove a mid-line catheter (a catheter that is inserted into a vein in the antecubital fossa and then advanced three to 12 inches into the proximal (near the center) upper arm) or any type of central venous catheter.

Review of the facility's LPN Job Description, undated, showed:
-IV certified LPNs may manage IVs within the restrictions of his/her certification. They may not administer IV push medications, may not add medication to IV fluids and may not access an implanted port;
-See that all physician orders are carried out or appropriate arrangements made.

Review of the facility's investigation, dated 1/29/25 through 1/30/25, showed:
-On 1/29/25, nurse discontinued IV PICC line on 1/28/25;
-On 1/28/25, Register Nurse (RN) placed call to Infectious Disease (ID) to obtain order to remove at 9:47 A.M.;
-On 1/28/25, resident requested PICC line to be discontinued;
-On 1/28/25, an order was obtained (LPN) at 9:51 P.M.,
-On 1/29/25, no adverse outcome, educated LPN on practice;
-On 1/30/25, no adverse outcome.

Review of the nursing schedule dated 1/28/25, showed, 2:30 P.M. through 11:00 P.M. there was two RNs scheduled and 10:30 P.M. through 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 694	Continued From page 10	F 694		

A.M., there was one RN was scheduled.

Review of LPN Z's employee file, showed:
-LPN had an active license and was IV certified;
-The Counseling Form dated 1/29/25, showed:
-When performance or behavior issues arise, a counseling session is used to help employees focus on the area of concern. The issue that leads up to this counseling is: removed PICC line;
-In order to achieve acceptable level of performance, the following change(s) must take place: you must practice within your scope. LPN may insert, remove IV lines that are three inches or less in length. You may administer medications and flush a PICC line;
-As an employer, we will provide the following support, training and/or coaching to help you achieve this goal: if procedures come up or orders are obtained that are not within your scope of practice you must defer the procedure to an RN or report to the Director of Nursing (DON) so he/she can delegate;
-Services we suffer when we do not follow proper procedures or behave in an acceptable manner. The consequence of this is: termination on any other practice completed by you that is outside your scope of practice;
-The form was signed by the LPN Z, the DON and the Administrator on 1/30/25.

Review of Resident #142's admission quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/7/25, showed:
-Cognitively intact;
-Diagnoses included: wound infection;
-Had IV access while a resident.

Review of the resident's quarterly MDS, dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 694	Continued From page 11	F 694		

3/25/25, showed:
-Cognitively intact;
-Diagnoses included: heart failure, high blood pressure, wound infection, anxiety and depression.

Review of the care plan in use at the time of survey, showed:
-Problem: Resident required IV medication;
-Goal: Resident will not exhibit signs of complications from IV (localized infection,(infection in one part of the body), systemic infection (an infection that has spread throughout the body), electrolyte imbalance, air embolus (one or more air bubbles or gas bubbles enter a vein or artery and block it) dislodgement, infiltration (the leakage of IV fluids or medications into the surrounding tissue instead of the vein), extravasation (leakage of a solution that can cause tissue damage), phlebitis (inflammation of a vein), fluid overload (occurs when the body receives more fluid than the body can process), dehydration);
-Interventions included: Discontinue IV at the first sign of infiltration or local inflammation. Created: 1/07/2025. Discipline: Nursing.

Review of the progress notes dated 1/27/25 through 1/28/25, showed:
-On 1/27/25 at 11:46 A.M., PICC line no signs and symptoms of adverse reaction noted, stop date for vancomycin (antibiotic) per pharmacy was 1/26/25;
-On 1/28/25 at 9:47 A.M., call placed to ID office to find out about PICC line removal order or if need any lab draw or follow up appointment. Will be faxing new orders to the facility;
-On 1/28/25 at 9:52 P.M., resident request the PICC line to be removed due to possible

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 694	Continued From page 12	F 694		

infiltration/line unable to be flushed and because line was dislodged and hanging from site barely intact. Call place to Medical Doctor (MD). New order, ok to remove PICC line until further orders received from infection control.

Review of the Medication Administration Record (MAR) dated 1/1/25 through 1/31/25, showed:
-A physician order to remove the PICC line;
-Documentation showed on 1/28/25 at 10:00 P.M., the PICC line was removed by LPN Z.

During an interview on 4/9/25 at 6:55 A.M., the resident said he/she did not recall any issues with his/her PICC line. The staff administered his/her medications and flushed it without any problems. The dressings were changed weekly.

During an interview on 4/8/25 at 3:15 P.M., LPN Z said LPNs could administer medications and flush PICC lines. They could also change the dressings and remove them in an emergency. The resident had a PICC line in his/her left arm and he/she wanted it out. LPN Z went into the room to assess the resident. The PICC line was not intact, the line was exposed three to four inches and the dressing had come loose. Basically, the line came out, they were no longer stitching the PICC lines in place. LPN Z said in the moment he/she was concerned the resident could go septic (a severe and potentially life-threatening response to an infection, often triggered by bacteria) because the resident had Methicillin-Resistant Staphylococcus Aureus (MRSA, infection is caused by a type of staph bacteria that's become resistant to many of the antibiotics) on his/her skin. The nurse called the physician and obtained an order to discontinue the PICC line. He/She did not have to pull too

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 694	Continued From page 13	F 694		

much to remove the PICC line. The PICC line was discontinued on the night shift and there was no RN in the building. There was an on-call supervisor, but he/she did not call them. The DON was notified the next day, and she provided education on what LPNs could do and she clarified the difference between the IV lines.

During an interview on 4/9/25 at 8:55 A.M. LPN AA said LPNs could flush and administer medications through the PICC line. LPNs could not discontinue them.

During an interview on 4/10/25 at 10:10 A.M., LPN S said LPNs could not discontinue PICC lines. If he/she got an order to discontinue it, he/she would tell the Assistant Director of Nursing (ADON) or the DON.

During an interview on 4/8/25 at 2:03 P.M. and at approximately at 4:00 P.M., and on 4/9/25 at 9:23 A.M., the DON said LPNs could administer medications and flush PICC lines. LPNs could not remove them. The resident wanted his/her PICC line out. The day nurse called the ID doctor and left a message. The evening nurse, LPN Z, called the primary care physician and obtained an order to remove the PICC line. Then, he/she went into the resident's room and removed it. As far as the DON knew, the PICC line was intact at the time it was removed. There was an RN in the building on both the evening and the night shift that day. LPN Z did not know he/she could not remove the PICC line and that it was out of his/her scope of practice. LPN Z was provided education on his/her scope of practice and the difference between the lines. If an LPN obtained an order to discontinue a PICC line and/or there was no RN in the facility, the DON would expect for the nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

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F 694	Continued From page 14 to leave the line in place and notify a RN/nurse manager or the DON. The DON also expected staff to practice within their scope of practice.	F 694		
	MO00250188			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

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F 756	Continued From page 15	F 756		

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to timely address the pharmacist recommendations from the Drug Regimen Review (DRR) for two residents (Residents #157 and #16). The sample was 35. The census was 181.

Review of the facility's DRR policy, dated reviewed 5/21, showed:
-Policy: the consultant pharmacist reviews the medications for each resident for any irregularities and to: verify appropriateness of the medications involved; evaluate disease state management; ensure appropriate medication monitoring to maximize safety and efficacy; and prioritize patient goals, safety, and quality of life;
-Procedures: the consultant pharmacist reviews each resident chart to identify and address any irregularities: medication duration and medication monitoring;
-The consultant pharmacist will review the chart of every resident each month and document the DRR as follows: the consultant pharmacist will utilize a current census or resident lists in the electronic medical record (EHR) to ensure that all active residents have been reviewed each month;
-All recommendations (including "no recommendations") will be printed each month (within 72 hours of completing all the DRR's in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

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F 756	Continued From page 16	F 756		

facility) and sent to the corresponding Director of Nursing (DON) via a delivery company to distribute and get completed;
- Pharmacy consults should be signed, completed, and acted on within 30 days of being sent to the facility;
-The facility should write a description of their attempts to get the consult completed on the actual consult (or in response to the observation in EHR). For example, "faxed to physician on these dates; put in physician mailbox on this date", etc.;
-Each month the consultant pharmacist will follow up on previous consults, nursing consults will be repeated the following month if not completed; physician consults will be repeated 2 months later if not completed.

1. Review of Resident #157's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 1/3/25, showed:
-Readmission date of 3/13/25;
-Cognitively intact;
-Highly impaired vision;
-No behaviors or rejection of care;
-Diagnoses included: stroke, high blood pressure, diabetes, anxiety and depression.

Review of the physician order sheet, in use at the time of survey, showed a physician order for tobramycin 0.3%, instill one drop into left eye three times a day until healed and reassessed by the medical doctor (MD). Start date was 3/13/25.

Review of the Pharmacist Recommendation to Prescriber, dated 10/18/24, showed:
-Findings/recommendation: the resident has an order for tobramycin eye drops since 3/31/24 with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

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F 756	Continued From page 17	F 756		

special instructions of "until healed and reassessed by the MD". The pharmacist could not find any notes if this had been assessed and if the tobramycin could be discontinued. The optometrist notes from 5/6/24 dose does not mention this medication. Please clarify with MD;
-Prescribers comments: please contact ophthalmologist, dated 11/10/24.

Review of the eye clinic notes, showed:
-On 11/6/24, the note did not address the tobramycin;
-On 3/7/25, the visit was cancelled. Patient said the light was too bright and wasn't able to keep his/her eyes open for exam.

During an interview on 4/11/25 at 9:20 A.M., 9:40 A.M. and 12:24 P.M., the Assistant Director of Nursing (ADON) said the facility did not receive the recommendations the day the pharmacist reviewed the resident's chart. Sometimes it took a couple of weeks for the facility to receive the pharmacy recommendations. Once the recommendations were delivered, the DON divided the recommendations out by physician and put them in their folders to be reviewed during their next visit. Once the recommendations were reviewed, the MD or the nurse should put a note in the medical record. The eye clinic visited the facility twice a month, but the residents were only seen every six months. The ADON looked at the resident's medical record and did not see where the recommendation was addressed. The ADON said the nurse placed a call to the physician to ask about the recommendation. The physician said the resident could continue the eye drops. The ADON would have expected the pharmacy review to have been addressed before today.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

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F 756	Continued From page 18	F 756		

2. Review of Resident #16's quarterly MDS, dated 1/14/25, showed:
-Admission date of 9/7/2016;
-Cognitively intact;
-Diagnoses included heart disease, high blood pressure, diabetes, and high cholesterol.

Review of the resident's electronic pharmacist DRRs, dated 9/27/24, 12/13/24, and 2/3/25, showed:
-Please take the following actions: Resident receives the following lipid-lowering medication(s): Atorvastatin 40 milligram (mg) tablet;
-Package insert and clinical guidelines recommend periodic checks of fasting lipid panels to monitor therapy;
-None in chart since 4/2023;
-Check fasting lipid panel now and yearly going forward.

Review of the resident's laboratory results, showed the most recent lipid panel was on 4/4/23. The facility did not provide laboratory results after 4/23. No hard copies of the pharmacist DRR sheets were provided on the review dates referenced in the pharmacy DRR recommendations.

During an interview on 4/10/25 at 12:42 P.M., the DON said they would not address the pharmacist's DRR and/or recommendations until they received the actual hard copies which were provided by pharmacy staff a few days after the electronic versions were posted electronically. They then sort out the DRR sheets and distribute to corresponding providers. They scanned the DRR sheets into the electronic health records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 756	Continued From page 19 once the providers addressed the DRR. During an interview on 4/11/25 at 11:09 A.M., the Primary Care Physician (PCP) said he/she did not know how those three pharmacy DRR recommendations were missed. The PCP said if not scanned into the EHR, they would not be seen or addressed. He/She said the resident's previous lipid panels were good. He/She ordered to have the resident's lipid panel drawn and will be done for the 5/2/25 schedule. 3. During an interview on 4/11/25 at 11:59 A.M., the Pharmacy Consultant said all their DRR sheets were delivered to the facility a few days after being posted electronically. The providers may not be able to address the recommendations, depending on the timing of the visits, for up to three weeks. The pharmacy sends a monthly summary of all the residents reviewed, through email, in addition to the individual sheets provided. 4. During an interview on 4/11/25 at 11:43 A.M., the DON said she expected the staff to make sure the monthly Pharmacist DRRs were addressed timely and to follow the provider's orders.	F 756		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 759	Continued From page 20	F 759		

Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Out of 37 opportunities observed, five errors occurred resulting in a 13.51% error rate (Residents #67, #112, #157 and #141). The census was 181.

Review of the facility's Insulin Administration via Pen Devices policy, last reviewed 5/2021, showed:
-Purpose: To safely administer insulin via pen devices according to physician orders and facility recommendations;
-Insulin pens containing multiple doses of insulin are meant for use on a single person only and should never be used for more than one person, even when the needle is changed. Insulin pens should be clearly labeled with the person's name or other identifying information to ensure that the correct pen is used only on the correct individual;
-Remove the pen cap and cleanse the rubber stopper wit an alcohol wipe Attach pen needle to device;
-Prime the pen immediately before injection. Priming is dialing up 2 units of insulin and pressing the button on the top of the pen to "shoot" some insulin into the air. You should see a drop of insulin at the end of the needle. More than one prime may be required for a new pen;
-Dial up the dose on the pen as indicated on the order;
-Verify that insulin is being given at the correct time in relation to meals;
-For Humalog (short acting insulin) administer 15 minutes before a meal or immediately following.

1. Review of Resident # 67's medical record, showed:
-Diagnoses included diabetes and dementia;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 759	Continued From page 21	F 759		

-An order dated 4/07/25, for insulin Humalog (short acting insulin) administer 8 units subcutaneous (under the skin) three times a day with meals at 8:00 A.M., 12:00 P.M. and 5:00 P.M.

Observation on 4/08/25, at 7:26 A.M., showed Licensed Practical Nurse (LPN) D obtained a blood sugar result of 115. LPN D drew up 8 units of Humalog after priming 2 units. LPN D administered the insulin into the resident's left arm without pinching the skin to ensure the insulin was administered subcutaneous. He/she existed the room. Resident #67 was not brought to breakfast until 8:13 A.M., were he/she was observed holding his/her head. When asked what's wrong, he/she said, "I feel sick to my stomach, and they bring me to lunch." At this time, no residents in the unit dining room were served breakfast. Staff served the resident breakfast at 8:34 A.M. (1 hour and 8 minutes after he/she received short acting insulin).

2. Review of Resident #112's medical record, showed:
-Diagnoses included diabetes;
-An order dated 4/2/25, for insulin aspart (short acting insulin) administer 18 units three times a day with meals;
-An order dated 4/2/25, for Lantus Solostar (long-acting insulin), administer 30 units daily, scheduled administration time between 7:15 A.M. and 11:15 A.M. daily.

Observation on 4/8/25 at 7:24 A.M., showed LPN E entered the resident's room and obtained a blood sugar result of 158. He/She obtained the resident's insulin aspart pen, placed the needle on the pen, and set the pen to administer 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 759	Continued From page 22	F 759		

units. He/She administered the insulin into the resident's abdomen. The insulin pen was not primed prior to administration. LPN E said he/she would administer the resident's Lantus after he/she obtained a Lantus pen from stock. At 8:35 A.M., LPN E obtained the resident's Lantus pen, placed the needle on the pen, and set the pen to administer 30 units. He/She administered the insulin into the resident's abdomen. The insulin pen was not primed prior to administration.

3. Review of Resident #157's medical record, showed:
-Diagnoses included diabetes;
-An order dated 3/13/25, for Basaglar (long-acting insulin) pen, administer 10 units every 12 hours, scheduled at 8:00 A.M. and 8:00 P.M.

Observation on 4/8/25 at 7:41 A.M., showed LPN E obtained a blood sugar level of 104. LPN E obtained the resident's Basaglar insulin pen, placed the needle on the pen, and set the pen to administer 10 units. He/She administered the insulin into the resident's left upper arm. The insulin pen was not primed prior to administration.

4. Review of Resident #141's medical record, showed:
-Diagnoses included diabetes;
-An order dated 8/7/24, for Humalog insulin pen, administer 7 units with meals;
-An order dated 8/7/24, for Humalog sliding scale insulin, administer no additional insulin for a blood sugar below 200.

Observation on 4/8/25 at 8:17 A.M., showed LPN E obtained a blood sugar level of 189. The resident said he/she already ate breakfast of cereal and an egg and sausage sandwich. LPN E

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 759	Continued From page 23 obtained the resident's Humalog insulin pen, placed the needle on the pen, and set the pen to administer 7 units. He/She administered the insulin into the resident's upper arm. The insulin pen was not primed prior to administration. 5. During an interview on 4/10/15 at 1:50 P.M., with the Director of Nursing (DON) and Infection Preventionist, they said when administering insulin, staff should follow the facility policy on how close to mealtime the insulin should be administered. The risk of too much time going by between administration of a short acting insulin is hypoglycemia (low blood sugar level). Staff should follow facility policy on priming insulin pens. The standard is to prime with 2 units. Not priming the insulin pen could result in the wrong dose of insulin being administered. Blood sugar levels should be checked prior to the resident eating their meal. If a blood sugar level is obtained after the resident eats, the results would not be accurate, and they would get the wrong dose of sliding scale insulin.	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 761	Continued From page 24	F 761		

biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were stored in accordance with acceptable standards of practice. The facility identified five medication rooms. Issues were found in two of the three medication rooms checked. Staff failed to double-lock the refrigerated controlled medications. The sample was 35. The census was 181.

Review of the facility's Medications, Controlled Drugs policy, last revised 2/2023, showed:
-All controlled medications must be stored in separately locked area that requires a different key;
-Refrigerated Ativan (Lorezepam) liquid and injectable medications require a small lock box for the refrigerator.

Review of the facility's Storage of Drugs policy, updated 12/21, showed compartments and areas containing drugs are locked when not in use or when left unattended. Such areas include drawers, cabinets, rooms, refrigerators, carts and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 761	Continued From page 25 boxes. Observation and interview 4/8/25 at 10:20 A.M., showed a refrigerator with no lock system in the medication room of Hall 300. There was an unlocked black box inside the refrigerator which contained two unopened bottles of Lorazepam Oral Concentrate (used to treat anxiety), 2 milligrams per milliliters (mg/ml). Licensed Practical Nurse (LPN) W said they did not have a lock to the refrigerator or to the black box. He/She said they never had to lock the box since the medication room door was always locked. The nurses and Certified Medication Technicians (CMTs) had access to the medication room and refrigerator. Observation and interview 4/8/25 at 11:15 A.M., showed a refrigerator with no lock system in the medication room of Hall 500. The unlocked black box inside the refrigerator contained five Lorazepam Oral Concentrate bottles. Registered Nurse (RN) X said they never locked the black box. RN Y said those medications were to be discarded. The black box was always unlocked. They did not have a lock and key to the box. During an interview on 4/10/25 at 12:42 P.M., the Director of Nursing (DON) said the refrigerated controlled medications were to be stored in locked tackle boxes in each medication room. She expected the staff to double-lock the controlled medications. The nurses and CMTs should have the keys to the medication rooms and the tackle boxes.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 812	Continued From page 26 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to store food in accordance with professional standards for food service safety by failing to cover food and failed to ensure that expired thickened dairy products were discarded. The facility also failed to ensure kitchen equipment was kept clean during three of five days of observation. In addition, the facility failed to maintain records of dish washing temperature logs as well as chloride testing logs. Furthermore, the facility failed to follow the puree recipes for six of the seven purees observed and failed to ensure dishes were properly washed in between use. These deficient practices had the potential to affect all residents who consumed food from the facility kitchen. The census was 181.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 812	Continued From page 27	F 812		

1. Observation of the kitchen walk in (left side) cooler on 4/7/25 at 11:12 A.M., 4/8/25 at 3:13 P.M. and 4/9/25 at 11:15 A.M., showed:
-An opened box of turkey sausage links exposed to air;
-An opened box of sausage patties exposed to air;
-An opened box of bacon exposed to air.

2. Observation of the kitchen's large storage room on 4/7/25 at 11:12 A.M., 4/8/25 at 3:13 P.M. and 4/9/25 at 11:15 A.M., showed:
-Six-gallon size containers of mustard, with best by dates of 3/6/25;
-Two boxes that contained several containers of Thick and Easy Thickened Dairy Drink, with best by date of 3/6/25;
-One box that contained several containers of Thick and Easy Thickened Dairy Drink, with best by date of 4/2/25;
-One box of Ready Care Apple Juice, with best by date of 1/1/25.

3. Observation of the kitchen on 4/7/25 at 11:12 A.M. and 4/8/25 at 3:13 P.M. and 4/9/25 at 11:15 A.M., showed the following:
-The stove:
-Heavy caked-on stains on the stove burners;
-Heavy caked-on stains along the front of the stove;
-The double deep fryer:
-Old grease in the fryers;
-Baked on grease on strainers and along the inside of the fryers;
-Heavy caked-on stains along the front and on the side in between the grill;
-Stand-alone double oven:
-Heavy caked-on stains along the front

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 812	Continued From page 28	F 812		

inside doors;
-Heavy caked-on stains along the bottom, and sides of oven.

4. Review of the undated puréed food preparation policy, showed:
-Guideline: Puréed foods will be prepared, using standardized recipes to ensure quality, flavor, palatability, and maximum nutritive value;
-Procedure:
-Each menu cycle will be reviewed to ensure there is a puréed recipe for each item to be served;
-Standardized recipes will be used to prepare all puréed foods. The recipes will be adjusted according to the number of puréed diets needed, indicating seasoning and technique to ensure the highest quality;
-Recipes will not use water to thin puréed foods. Only broth, milk, juice, gravy, margarine, or another appropriate condiment that preserves flavor shall be used.
-Food thickener will be used only in accordance with a specific recipe or product instructions. Measure and add commercial thickener, stabilizer, or shaping/enhancing product as directed in the recipe and process until blended.
-Serve with appropriate scoop number or divide equally to provide an equal number portions. All of the pureed foods must be used in order to deliver the correct nutrient density to each resident. The number of servants obtained from the purée recipe must be equal to the number of servings from which you started. For example, if ten servings of the regular recipe are to be puréed, follow the purée recipe for ten servings. The yield of the puréed recipe must give you ten equal puréed servings. If the recipe was altered,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 812	Continued From page 29	F 812		

the scoop size may also need to be altered. Due to the nature of variance in foods, it is possible that slight alterations or not using all the liquid in a recipe will be required. Therefore, the division of an equal portion of final product to the starting number of servings insures equal nutritive value in each portion. Record this alteration information on the recipe with the date and your initials. Review altered puréed recipes with the facility Registered Dietitian.
-Puréed foods will be the consistency of pudding or smooth, mashed potatoes. A food processor is preferred; however, a blender may be used to make puréed foods.
-The flavor of puréed food will be assessed. The puréed food should have the same desirable flavor as the menu item.
-Staff will be in-serviced on proper preparation of puréed foods.

Observation on 4/9/25 at 7:18 A.M., showed Dietary Cook (DC) BB pureed eggs. During an interview at that time, DC BB said he/she was pureeing dishes for five residents. He/She used a jumbo-sized scoop that appeared to look like an ice scoop. He/She placed two full scoops, and two half sized scoops of unmeasured scrambled eggs into the food processor. DC BB poured an unmeasured amount of apple juice into the food processor and pureed the items for approximately ten seconds. He/She stopped and said the mixture needed more thickener and added three scoops of thickener at that time and added an additional unmeasured amount of apple juice and pureed the items for approximately ten more seconds. DC BB stopped the food processor and added an additional unmeasured amount of apple juice and pureed for another ten seconds. DC BB then stopped the food processor and stirred the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 812	Continued From page 30	F 812		

mixture. DC BB placed the mixture into four small metal aluminum pans and covered the pans with the lids. The consistency was somewhat thick but with a fluffy texture. The mixture was not smooth. Further observation showed DC BB did not consult the recipe book during the preparation.

Review of the pureed eggs recipe, showed the following for nine servings:
-Ingredients:
-Twelve #16 scoops of scrambled eggs (see recipe);
-3/4 cup of milk;
-Method:
-Count out the number of prepared scrambled eggs according to yield desired. Place in food processor;
-Add milk. Purée until smooth. Eggs will be thin cake batter consistency (will tighten up on steam table);
-Portion into steam table pans according to each dining room count. Cover and place in oven or warmer until serving time. Temperature 165 degrees.

Observation on 4/9/25 at 7:28 A.M., showed DC BB pureed bread. DC BB said sometimes he/she would use three or four loaves of bread so he/she would have enough. DC BB tore open the packaging and placed all the bread from four loaves of bread into the food processor. He/She then poured an unmeasured amount of apple juice into the food processor and pureed the items. As the items pureed, DC BB poured an additional unmeasured amount of apple juice through the opening in the lid and pureed the items for a total of approximately 20 seconds and then stopped the food processor. He/She poured an additional unmeasured amount of apple juice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 812	Continued From page 31	F 812		

into the food processor and then blended the mixture for approximately 15 seconds and stopped the blender. DC BB got another box of apple juice and poured an unmeasured amount of apple juice into the food processor and pureed the items for approximately 15 seconds. DC BB stopped the food processor and then added an unmeasured amount of apple juice and pureed the items for an additional 20 seconds. The consistency was thick but smooth in consistency. Further observation showed DC BB did not consult the recipe book during the preparation.

Review of the pureed bread recipe, showed the following for five servings:
-Ingredients:
-Five slices of bread;
-1/2 cup plus two tablespoons of milk.
Method:
-Place bread in blender or food processor;
-Gradually add milk; blend until smooth; chill until serving time. Serve chilled or reheat to 165° degrees;
-Portion with number 16 scoop.

Observation on 4/9/25 at 7:35 A.M., showed DC BB pureed ham. He/She rinsed out the bowl and rinsed off the lid of the food processor from the previous bread puree with water. There was still residue on the lid and batter on the inside on the sides of the bowl. DC BB placed 17 pieces chunks of ham inside the food processor and blended about ten seconds and stopped the food processor. He/She poured an unmeasured amount of apple juice inside the food processor. DC BB got another box of apple juice and poured an additional unmeasured amount of apple juice inside the food processor and blended for another 15 seconds. He/She stopped the blender and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 812	Continued From page 32	F 812		

added an additional unmeasured amount of apple juice and pureed the mixture for an additional 20 seconds. He/She placed the mixture into four small aluminum metal pans and placed lids on top of them. The mixture was gritty in consistency. The mixture was not smooth. Further observation showed DC BB did not consult the recipe book during the preparation.

Review of the pureed meat recipe, showed the following:
-Ingredients:
-Chicken, beef, liver, ham, pork, or fish;
-Method:
-Count out number of portions needed. Place in robot coupe;
-Add complementary broth to reach desired consistency;
-Should be between applesauce and mashed potato consistency;
-Thickener may be added as needed to reach the appropriate consistency;
- Reheat to 165.

Observation on 4/9/25 at 11:17 A.M., showed DC CC pureed pineapple coleslaw. DC CC placed three scoops of thickener, eight scoops of coleslaw and an unmeasured amount of apple juice inside the food processor and pureed the items for approximately ten seconds. He/she stopped the food processor and placed three more scoops of slaw and an additional unmeasured amount of apple juice inside the blender and pureed the items for an additional 30 seconds. DC CC stopped the food processor and said he/she would "eyeball" the mixture to make sure it was correct and then he/she pureed the mixture for an additional 30 seconds. DC CC placed the mixture into four small aluminum

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

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F 812	Continued From page 33	F 812		

metal pans and placed lids on top of them. The mixture was gritty but soupy in consistency. Further observation showed DC CC did not consult the recipe book during the preparation.

Review of the pureed fruit recipe, showed the following:
-Ingredients:
-Canned fruit or fresh fruit;
-Method:
-Count out number of portions needed;
-Drain canned fruit and place in blender. Fresh fruit in robot coupe;
-Pureed until consistency of applesauce or thicker;
-Juice or thickener may be added to reach consistency.

Observation on 4/9/25 at 11:27 A.M., showed (DC) CC prepared pureed salami, turkey, and pepperoni. DC CC placed four scoops of thickener, nine scoops of salami, turkey, and pepperoni along with an unmeasured amount of beef broth inside the food processor inside the food processor and pureed the items for approximately 45 seconds. He/She stopped the food processor, looked at the mixture, and then poured an additional unmeasured amount of beef broth inside the food processor and stopped it. DC CC pureed the mixture for an additional 35 seconds. He/She stopped the food processor and poured the mixture inside of four small aluminum metal pans. Further observation showed DC CC did not consult the recipe book during the preparation.

Review of the pureed meat recipe, showed the following:
-Ingredients:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 812	Continued From page 34	F 812		

-Chicken, beef, liver, ham, pork, or fish;
-Method:
-Count out number of portions needed. Place in robot coupe;
-Add complementary broth to reach desired consistency;
-Should be between applesauce and mashed potato consistency;
-Thickener may be added as needed to reach the appropriate consistency;
- Reheat to 165.

Observation on 4/9/25 at 11:32 A.M., showed DC CC prepared pureed rolls. DC CC placed three scoops of thickener, a package of rolls, and an unmeasured amount of two percent milk inside the food processor and pureed the items for approximately 15 seconds. He/She stopped the food processor and added an unmeasured amount of two percent milk inside the food processor and pureed the items for another 20 seconds. DC CC stopped and said he/she probably needed to add a little more bread. He/She placed three hamburger buns inside the food processor and pureed the mixture for an additional 20 seconds. The mixture was smooth in consistency. Further observation showed DC CC did not consult the recipe book during the preparation.

Review of the pureed bread recipe, showed the following for five servings:
-Ingredients:
-Five slices of bread;
-1/2 cup plus two tablespoons of milk.
-Method:
-Place bread in blender or food processor;
-Gradually add milk; blend until smooth; chill until serving time. Serve chilled or reheat to 165°

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 812	Continued From page 35	F 812		

degrees;
-Portion with number 16 scoop.

5. Observation on 4/9/25 at 11:27 A.M., showed DC CC prepared pureed salami, turkey, and pepperoni. He/She rinsed out the bowl and the lid from the previous pureed onion ring puree. After (DC)CC rinsed the bowl and lid off, residue from the onion ring puree was on the lid and batter was along the inside of the bowl. (DC) CC proceeded to puree the salami, turkey, and pepperoni at that time.

6. Observation of the kitchen on 4/7/25 at 11:12 A.M., 4/8/25 at 3:13 P.M., 4/9/25 at 11:15 A.M. and 4/11/25 at 11:28 A.M., showed:
-Incomplete temperature logs for April 1-11, 2025;
-No temperature logs for February and March 2025;
-No logs for testing the chloride for February, March, and April 2025.

7. During an interview on 4/11/25 at 11:28 A.M., the Dietary Manager (DM) said she expected all food and drinks to be properly labeled, dated and stored, and for all expired items to be discarded. She expected all kitchen equipment to be clean and in proper working order. General cleaning is done every day and deep cleaning of certain items is done daily and some are done weekly. During the dish cleaning cycle, the temperatures are taken and recorded. Staff should be running the machines twice to make sure everything is working properly. The temperatures should be taken at breakfast, lunch and dinner everyday and logged. The test strips to test the chloride in the water should be used as well and logged after every dish washing cleaning service. This is done to make sure that the dishes are being sanitized.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 812	Continued From page 36 This should be done regularly. This was her expectation. She expected proper infection control practices followed while preparing food as well as ensuring dishes are thoroughly cleaned in between use. The DM expected staff follow puree recipes. The recipes should be followed so the food had the right consistency and texture and the flavor should match the food. The texture is part of the consistency. She was not aware the staff used apple juice for a lot of the purees. She expected the puree recipe book to have been opened and used during the preparation of pureed meals. The staff who did the purees worked there for years so he/she knew how to do the purees. They should read the book to make sure nothing changed. She expected the dishes to have been properly cleaned. You don't want bread to taste like meat. She would want the food items to taste like what it is supposed to be.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 880	Continued From page 37	F 880		

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 880	Continued From page 38	F 880		

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to follow acceptable infection control practice during care of residents. Staff failed to follow Centers for Disease Control and Prevention (CDC) guidance for Personal Protective Equipment (PPE) use for one resident with a contagious form of diarrhea and failed to ensure the facility policy for isolation was held to the same standard as the CDC guidance (Resident #424). Staff failed to ensure insulin pens were only for single resident use for one resident (Resident #67) when staff prepared to administer a different resident's insulin pen to the resident, prior to being stopped by the surveyor. Staff failed to follow proper enhanced barrier precaution (EBP, precautions used on residents with high risk of getting infections, who are not infectious themselves) for one resident who received personal care (Resident #22). Staff failed to cleanse the shared blood sugar machine with approved cleansing products between each resident use for four residents (Resident #112, #157, #32, and #141). Staff failed to follow proper infection control practices during medication administration for one resident (Resident #57) when staff administered a pill that had dropped on the medication cart, with their ungloved hands. In addition, staff failed to ensure resident laundry

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 880	Continued From page 39	F 880		

was covered when transported through the halls. The sample was 35. The census was 181.

1. Review of the facility's Clostridioides Difficile (C-diff., a very contagious bacterial infection that causes symptoms such as frequent watery diarrhea) Infection policy, dated 2/21, showed:
-Policy: it is the policy of this facility to institute contact precautions for residents with known C-diff who are exhibiting diarrhea stools due to the infection in the following situations: when the resident is incontinent and soiling of the environment with stool is likely, when the resident is noncompliant with basic personal hygiene and hand washing, when contaminated stool cannot be contained, or when the resident is confused and cannot comply with appropriate hygiene measures;
-Procedure: gowns should be worn if direct care (bathing or lifting) is provided.

Review of the CDC.gov/c-diff/hcp/clinical overview, dated 3/5/24, showed, treatment and recovery, if C-Diff infection is confirmed, continue isolation and contact precautions.

Review of Resident #424's medical record, showed:
-Resident can make his/her needs known;
-Diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following stroke affecting left non-dominant side.

Review of the resident's care plan, in use at the time of survey, showed:
-Problem: Resident had a deficit in functional ability with activities of daily living (ADLs, grooming, dressing, bathing and hygiene) for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 880	Continued From page 40	F 880		

self-care and mobility related to recent stroke, weakness and required mechanical lift assistance;
-Goal: will participate in ADL activities promoting maximum independence;
-Interventions included: provide assistance with ADLs as needed or requested: bed mobility assist times one, toilet/incontinent care assist times one.

Review of the resident's physician order sheet, showed an order, dated 4/3/25, for Vancomycin (antibiotic) 125 milligrams (mg) every six hours for nine days.

Review of the resident's progress notes, dated 4/6/25 at 9:20 A.M., showed the resident continues antibiotic/vancomycin 125 mg for C-diff until 5/1/25. Resident had one episode of diarrhea prior to breakfast meal.

Observation and interview on 4/8/25 at 8:20 A.M., showed the resident up in his/her wheelchair, in the dining room. Staff propelled the resident back to his/her room. There was an EBP magnet on the door frame. PPE hung on the bathroom door. Certified Medication Technician (CMT) Q and Certified Nurse Aide (CNA) R washed their hands in the resident's bathroom and put gloves on, then they attached the mechanical lift cloth to the mechanical lift and transferred the resident from his/her chair into bed. Staff assisted the resident to roll towards the window and staff tucked the mechanical lift pad under the resident. Staff then rolled the resident towards the door and the lift cloth was removed. CMT Q and CNA R removed their gloves, performed hand hygiene and put new gloves on. Staff unfastened the resident's brief and tucked it down between his/her legs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 880	Continued From page 41	F 880		

Staff then provided perineal care (peri-care, care to the surface area between the thighs, extending from the pubic bone to tail bone). CNA R said the resident was incontinent of bowel. Staff did not wear a gown during the transfer nor while providing direct resident care.

Observation on 4/9/25 at 6:50 A.M., 4/10/25 at 7:50 A.M., and 4/11/25 at 7:20 A.M., showed the EBP magnet remained on the door frame. No isolation sign was posted.

During an interview on 4/10/25 at 10:10 A.M., Licensed Practical Nurse (LPN) S said the resident was on EBP because he/she had C-diff.

During an interview on 4/10/25 at 9:20 A.M., CNA T said residents who had wounds or Covid had an EBP magnet outside their door. Staff should wear gloves, N95 mask, face shield and gown every time they enter the resident's room.

During an interview on 4/10/25 at 9:47 A.M., CNA U said residents who had wounds had an EBP magnet outside their door. He/She performed hand hygiene and wore gloves for all personal care. He/She did not know if any other PPE would be required or not.

During an interview on 4/10/25 at 10:10 A.M., LPN S said residents who have catheters or infections had an EBP magnet on their door frame. Staff should wear gloves and gowns while providing care. During report, the CMT/CNAs are made aware of which residents require PPE.

During an interview on 4/10/25 at 12:00 P.M., CNA R said he/she was made aware which residents required PPE during report. If the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 880	Continued From page 42	F 880		

resident had an EBP magnet outside their door, that meant the resident had an infection and staff should wear gown and gloves and if there are face shields by the door, they should also wear it. The PPE should be worn every time staff enter the room.

During an interview on 4/11/25 at 9:40 A.M., with the Director of Nursing (DON) and the Infection Preventionist (IP), the IP said she was responsible for putting the EBP magnets out. Residents who have wounds, intravenous lines (IV), catheters and gastric tubes would have a magnet placed outside their door. Staff should wear gown and gloves while providing direct patient care. If staff was transferring a resident with the mechanical lift and the resident was already dressed, the staff are not required to wear a gown. If staff was performing peri care on a resident, staff should wear a gown. If a resident had C-Diff and their BM was not contained, that resident would be placed on contact precautions, but if the BM was contained the resident was placed on EBP. If the resident is on contact precautions there would be a sign on the door, if the resident was on EBP they would have a magnet on the door frame. C-diff is highly contagious, staff should wear gown and gloves while providing direct patient care. If staff do not wear a gown there is potential for bacteria to get on their clothes or on their hands and they could spread it to other residents or staff. The IP said she would expect for staff to wear the proper PPE.

2. Review of the facility's Insulin Administration via Pen Devices policy, last reviewed 5/2021, showed:
-Purpose: To safely administer insulin via pen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 880	Continued From page 43	F 880		

devices according to physician orders and facility recommendations;
-Insulin pens containing multiple doses of insulin are meant for use on a single person only and should never be used for more than one person, even when the needle is changed. Insulin pens should be clearly labeled with the person's name or other identifying information to ensure that the correct pen is used only on the correct individual.

Review of Resident #67's medical record, showed:
-Diagnoses included diabetes;
-An order, dated 4/7/25 for Humalog insulin (short acting insulin) 8 units subcutaneous (under the skin) scheduled administration at 8:00 A.M., 12:00 P.M., 5:00 P.M.

Observation on 4/8/25 at 11:22 A.M., showed LPN D obtained the lunch blood sugar for the resident with a blood sugar result of 160. He/She obtained a Humalog insulin pen and set the pen to administer 8 units. Observation of the insulin pen, showed a different resident's name listed on the pen. Before he/she could administer the insulin, the observation was stopped by the surveyor to prevent cross contamination to Resident #67. LPN D acted surprised and confirmed he/she had the wrong resident's insulin pen. At this time, he/she had to pull a new insulin pen from the E-kit (medication stock) for the resident. LPN D then primed and then resumed to administer the resident's ordered insulin.

During an interview on 4/10/25 at 1:50 P.M., the DON confirmed that facility policy is for insulin pens to be assigned to the resident and insulin pens should never be shared among other residents for any reason.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 880	Continued From page 44	F 880		

During an interview on 4/10/25 at P.M., the IP said it is important to keep insulin pens designated to one resident as opposed to sharing. Sharing insulin pens could have potential harm for blood borne pathogens to spread from resident to resident. Staff were in-serviced last month, March 26 & 27 at their annual training, regarding safety hazards if an insulin pen was to be utilized as a community pen instead of a single resident use as designed. After the in-service each nursing staff were assigned a competency test to show compliance with the education provided.

3. Review of the facility's Enhanced Barrier Precautions policy, dated July 2022, showed:
-Purpose: To reduce the spread of multi-drug resistant organisms (MDRO);
-Residents with colonization of MDRO or with indwelling devices will be placed on EBP;
-Signage will be placed outside of their rooms to alert staff that PPE is needed;
-PPE should be worn during high-contact resident care activities: Dressing, bathing/showering/providing hygiene/changing briefs or assisting with toileting;
-Resident status: Has a wound or indwelling medical device without secretions or excretions that are unable to be contained and are not know to be infected or colonized with any MDRO: Use EBP.

Review of Resident #22's medical record, showed:
-Diagnoses included quadriplegia (paralysis or lack of function in all four limbs);
-A care plan, in use at the time of the survey, showed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 880	Continued From page 45	F 880		

-Problem start date 4/8/25: Category: Infection: Resident is at risk for contracting MDRO due to wound that requires the use of PPE during high contact activities;
-Approach: Resident is on EBP. Staff must perform hand hygiene before and after providing care. Staff to wear gloves and gowns when providing high contact activities.

Observation on 4/9/25 at 7:34 A.M., showed the resident in bed. CNA V stood at the resident's bedside and wore gloves with no gown on. CNA V assisted to lower the resident's pants and provided perineal care. The resident was incontinent of bowel. CNA V assisted the resident to roll to his/her left side and then the right. As he/she assisted the resident to roll, his/her clothing pressed up against the resident. A dressing intact to the resident's buttocks was visible. After providing care, CNA V assisted the resident to use a urinal and get dressed. No gown was worn during care. Observation in the resident's room, showed a PPE caddy with gowns available. Observation of a sign outside the resident's room, showed EBP, perform hand hygiene and wear a gown and gloves.

During an interview with the DON and IP on 4/10/25 at 2:15 P.M., they said if a resident is on EBP, a gown should be worn during perineal care because staff are attempting to curb the spread of the infection.

4. Review of the facility's Blood Glucose Monitors (Equipment Cleaning) policy, last revised February 2021, showed:
-Purpose: To prevent the spread of blood borne pathogens;
-Equipment used to obtain blood glucose (sugar)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 880	Continued From page 46	F 880		

results that are used for more than one resident will be cleaned before and after each use;
-A container of Oxivir TB (disinfectant) will be stored in each treatment cart;
-Before and after the testing procedure, the nurse will cleanse the monitor with the Oxivir TB.

Review of Resident #112's medical record, showed:
-Diagnoses included diabetes;
-An order dated 4/2/25 for insulin aspart (short acting insulin) administer 18 units three times a day with meals. The medication administration record required a documented blood sugar before administration.

Review of Resident #157's medical record, showed:
-Diagnoses included diabetes;
-An order dated 3/13/25, for blood sugar check every 12 hours, scheduled at 8:00 A.M. and 8:00 P.M.

Review of Resident #32's medical record, showed:
-Diagnoses included diabetes;
-An order dated 1/22/25, for blood sugar check twice a day, scheduled between 7:15 A.M. through 11:15 A.M. and 7:15 P.M. through 11:00 P.M.

Review of Resident #141's medical record, showed:
-Diagnoses included diabetes;
-An order dated 8/7/24, for Humalog (short acting insulin), administer 7 units with meals. The medication administration record required a documented blood sugar before administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 880	Continued From page 47	F 880		

Observation on 4/8/25 at 7:23 A.M., showed LPN E obtained a blood sugar machine from the medication cart and obtained a blood sugar result from the resident. He/She then wiped off the blood sugar machine with an alcohol wipe and placed the machine back into the top drawer of the medication cart. At 7:41 A.M., LPN E propelled the medication cart to the room of Resident #157. He/She obtained the resident's blood sugar result and cleaned the machine with the approved disinfectant wipes located in the bottom drawer of the medication cart. At 7:53 A.M., LPN E went to the room of Resident #32 and obtained a blood sugar result from the resident. The blood sugar machine was placed directly on the medication cart after use while LPN E administered insulin to the resident. LPN E returned to the medication cart and cleaned the machine with an alcohol wipe. At 8:06 A.M., LPN E went to the room of Resident #141. He/She obtained the resident's blood sugar result and cleaned the machine with the approved disinfectant wipes located in the bottom drawer of the medication cart. LPN E said he/she is agency and really does not get any orientation when coming to the facility for the first time. He/She can ask the staff about care needs of the residents.

During an interview with the DON and IP on 4/10/25 at 2:15 P.M., they said staff should use Oxivir wipes to cleanse the blood sugar machines between resident use. Machines are not to be cleaned with alcohol.

5. Review of Resident #57's electronic Medication Administration Record (eMAR), for April 2025, showed orders for:
-Acetaminophen (Tylenol) tablet 500 mg, administer 1000 mg by mouth three times a day;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 880	Continued From page 48 -Bethanechol chloride (for urinary retention) tablet, administer 25 mg by mouth three times a day; -Bisacodyl (for constipation) tablet 5 mg, administer 2 tablets once a day, every other day; -Diltiazem HCl (for high blood pressure) tablet 120 mg, administer 1 tablet by mouth once a day; -Docusate sodium (for constipation) tablet 100 mg, administer by mouth once a day; -Eliquis (blood thinner) tablet 2.5 mg, administer by mouth twice a day; -Ergocalciferol (vitamin D2, for vitamin d deficiency) capsule by mouth, 1,250 micrograms (mcg) or 50,000 units, administer one capsule by mouth, once a day on Mondays; -Furosemide (for fluid retention) table 20 mg, administer 1 tablet by mouth once a day; -Magnesium oxide (for constipation) tablet 400 mg, administer 1 tablet by mouth once a day; -Montelukast (for asthma) tablet 10 mg, administer 1 tablet by mouth once a day. During a medication administration observation on 4/8/25 at 8:10 A.M., showed CMT P prepared the residents ordered medication. He/She dropped one of the resident's pills directly on the medication cart. CMT P picked up the pill with his/her bare hand and placed it back in the medication cup with the other pills, then administered them to the resident. The medication cart had some white laxative powder spills on top of the cart when the CMT dropped and picked up the pill. During an interview on 4/11/25 at 9:40 A.M., the DON said if a staff member dropped a pill, she expected him/her to discard the pill and obtain a new one.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265105	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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 880	Continued From page 49 6. Observation on 4/8/25 at 6:27 A.M., showed Laundry Attendant A propelled an uncovered laundry rack full of resident personal clothing, down the 400 halls. At 6:29 A.M., Laundry Attendant A said the facility does all their own laundry. They do not outsource any laundry. They do linen, towels, resident clothing, etc. they have staff on all shifts. Day, evening, and night. Observation of the laundry room on 4/9/25 at 10:36 A.M., showed two different types of personal laundry racks. One that had a cover and one that did not. Laundry Attendant B said resident personal clothes are transported to the halls using the hanging cart with a cover. The uncovered cart is for laundry room use only. During an interview with the DON and IP on 4/10/25 at 2:15 P.M., they said clean resident clothing should be covered when transported down the hall. If not covered, contamination could occur.	F 880		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02120	A. BUILDING: _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

(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) COMPLETE DATE
A4055	19 CSR 30-85.042(46) Safe/Effective Medication System There shall be a safe and effective system of medication distribution, administration, control, and use. I/II This regulation is not met as evidenced by: Class II See deficiency cited at F759.	A4055		
A4061	19 CSR 30-85.042(52) Drug Regimen Review-Monthly At least monthly a pharmacist or a registered nurse shall review the drug regimen of each resident. Irregularities shall be reported in writing to the resident's physician, the administrator, and the director of nurses. There must be written documentation which indicates how the reports were acted upon. II/III This regulation is not met as evidenced by: Class III See deficiency cited at F756.	A4061		
A4065	19 CSR 30-85.042(56) Schedule II Meds-Storage Facilities shall store Schedule II medications, including those in the emergency drug supply, under double lock separately from noncontrolled medication. Schedule II medications may be stored and handled with other noncontrolled medication if the facility has a single unit dose drug distribution system in which the quantity stored is minimal and a missing dose can be readily detected. II	A4065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02120	A. BUILDING: _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A4065	Continued From page 1 This regulation is not met as evidenced by: See deficiency cited at F761.	A4065		
A4074	19 CSR 30-85.042(65) Protective Oversight, Voluntary Leave Each resident shall receive twenty-four- (24-) hour protective oversight and supervision. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Class II See deficiency cited at F689.	A4074		
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 See deficiency cited at F694.	A4075		
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread	A4086		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02120	A. BUILDING: _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

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A4086	Continued From page 2 of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II This regulation is not met as evidenced by: Class II See deficiency cited at F880.	A4086		
A5004	19 CSR 30-85.052(4) Food Texture-Chewing Difficulty Special attention shall be given to the texture of food given to residents who have chewing difficulty. II/III This regulation is not met as evidenced by: Class II* See the deficiency cited at F812. *The higher classification merited due to the extent of the violation.	A5004		
A6025	19 CSR 30-87.020(25) Plumbing per Code Plumbing shall be sized, installed and maintained according to the National Plumbing Code. II/III This regulation is not met as evidenced by: Class III See deficiency cited at F584.	A6025		

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	02120	A. BUILDING: _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

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A7015	Continued From page 3	A7015		
A7015	19 CSR 30-87.030(13) Food-Protected, Temp, Need to Contact DHSS At all times, including while being stored, prepared, displayed, served or transported to or from the facility, food shall be protected from potential contamination, including dust, insects, rodents, unclean equipment and utensils, unnecessary handling, coughs and sneezes, flooding, drainage and overhead leakage or overhead drippage from condensation. The temperature of potentially hazardous food shall be forty-five degrees Fahrenheit (45°F) or below or one hundred forty degrees Fahrenheit (140°F) or above at all times, except as otherwise provided in this section. In the event of a fire, flood, power outage or similar event that might result in the contamination of food, or that might prevent potentially hazardous food from being held at required temperatures, the person in charge shall immediately contact the Department of Health and Senior Services (the department). Upon receiving notice of this occurrence, the department shall take whatever action that it deems necessary to protect the residents. II/III This regulation is not met as evidenced by: Class III See deficiency cited at F812.	A7015		
A7019	19 CSR 30-87.030(17) Food Stored in Identifying Containers Unless its identity is unmistakable, bulk food, such as cooking oil, syrup, salt, sugar or flour not stored in the product container or package in which it was obtained, shall be stored in a container identifying the food by common name.	A7019		

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	02120	A. BUILDING: _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS WEST	13550 SOUTH OUTER 40 ROAD TOWN AND COUNTRY, MO 63017

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A7019	Continued From page 4 III This regulation is not met as evidenced by: See deficiency cited at F812.	A7019		
A7056	19 CSR 30-87.030(54) Nonfood Contact Surfaces, Cleaning Surfaces of equipment not intended for contact with food, but which are exposed to splash or food debris or which otherwise require frequent cleaning, shall be designed and fabricated to be smooth, washable, free of unnecessary ledges, projections or crevices, and readily accessible for cleaning, and shall be of such material and in a repair as to be easily maintained in a clean and sanitary condition. III This regulation is not met as evidenced by: See deficiency cited at F812.	A7056		
A7065	19 CSR 30-87.030(63) Food-Contact Surfaces Washed/Rinsed/Sanitized Where equipment and utensils are used for the preparation of potentially hazardous foods on a continuous or production-line basis, utensils and the food-contact surfaces of equipment shall be washed, rinsed and sanitized at intervals throughout the day on a schedule based on food temperature, type of food and amount of food particle accumulation. III This regulation is not met as evidenced by: See deficiency cited at F812.	A7065		
A7077	19 CSR 30-87.030(75) Dishwashing Machine Types	A7077		

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A7077	Continued From page 5 Cleaning and sanitizing may be done by spray-type or immersion dishwashing machines or by any other type of machine or device if it is demonstrated that it thoroughly cleans and sanitizes equipment and utensils. In a facility with a licensed capacity of twelve (12) or fewer beds, a home-type dishwashing machine shall be acceptable. If a new machine is purchased, it shall be one with sanitizing capabilities. In a facility licensed for a larger capacity, if a dishwasher is used, it shall meet the requirements in sections (72)-(74) of this rule. Machines and devices shall be properly installed and maintained in good repair; shall be operated in accordance with manufacturers ' instructions; and utensils and equipment placed in the machine shall be exposed to all dishwashing cycles. Automatic detergent dispensers, wetting agent dispensers and liquid sanitizer injectors, if any, shall be properly installed and maintained. II/III This regulation is not met as evidenced by: Class III See deficiency cited at F812.	A7077		

PLAN OF CORRECTION

Provider/Supplier Name:	Delmar Gardens West
Street Address, City, Zip:	13550 S Outer 40 Rd, Town and Country, MO 63017-5812
Date of Survey:	04/11/2025

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
	Public Notice and Disclaimer: This plan of correction is signed and submitted as required under State and Federal law. The signing and submission of this plan does not constitute an admission on part of Delmar Gardens West ("Community") as to the accuracy of the surveyor's findings or the conclusions drawn there from. The plan of correction does not constitute an admission on the part of the Community or employees that the findings cited are accurate, that the findings constitute a deficiency or the scope and severity regarding any of the deficiencies cited is correctly applied. Any changes to Communities policies and procedures shall be considered to be subsequent remedial measures as that concept is applied 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 shall be inadmissible by any third party in any regulatory, civil or criminal action against the facility or any employee, agent, officer, director or shareholder of the facility. **Global completion date: May 13, 2025**	

F584	The Community will continue to ensure that residents are treated and cared for in a safe, clean, comfortable and homelike environment. Resident #53 continues to reside in the community and the shower drain in her room was cleared of obstructions the same day the maintenance staff were notified of the blockage. The Community Maintenance Director/designee will in-service staff on the procedure to report maintenance issues using the maintenance work order form or contacting the front desk who will complete a maintenance work order form. New employees will be educated on this practice during orientation. Ongoing training will occur as needed. The Community Maintenance Director/designee will perform audits on 5 maintenance work orders to ensure completion weekly for 12 weeks. The Community Maintenance Director/designee will report the finding during the monthly QAA meetings.	**5/13/2025**
F689	The Community will continue to ensure that the environment remains free of accident hazards as much as possible and that each resident received adequate supervision and assistance to prevent accidents. Resident #67 continues to reside comfortably in the Community and receive care according to orders and plan of care. On 4-7-2025 an order was obtained for PT/OT/ST evaluation to assess and re-evaluate the needs of the resident including his/her transfer ability. His/Her transfer status has been re-evaluated and orders obtained reflecting his/her current transfer ability. Residents requiring assistance with transfers have the potential to be affected by the practice observed by the surveyor. As a result, the Director of Nursing and /or designee will complete education for all nursing staff on the Community's transfer policy. New Nursing employees will be educated on the Community's transfer policy during new employee	**5/13/2025**

	orientation. Ongoing education will be provided to staff yearly and as needed. The DON and/or designee will conduct random observations of 5 residents transfers per week who require gait belt assistance to ensure proper assist level and technique is utilized per Community's policy. Any noted infractions will be addressed at the time of discovery. Audits will continue for 12 weeks. Compliance findings will be discussed monthly by DON/Designee during QAA Committee Meeting monthly for three months.	
F694	The Community will continue to ensure Parenteral fluids are administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Resident #142 continues to reside comfortably in the Community and receive care per orders and care plan. He/She has had no adverse outcome from the PICC Line removal. All Nurses were immediately in-serviced during the survey regarding the management of IVs within the restrictions of his/her certification. All Nurses were also in-serviced to notify the DON and/or ADON when obtaining physician orders that would be outside the restrictions of his/her certification. New Nurse employees will be educated on the Community's IV Policy during new employee orientation. Ongoing education will be provided to licensed nursing staff as needed. DON/designee will interview 3 nurses a week for 12 weeks on the extent of their scope of practice in relations to IVs and PICC removal. Any concerns observed will be addressed at that time. Education Compliance will be discussed monthly by DON/Designee during QAA Committee Meeting.	**5/13/2025**
F756	The Community will continue to ensure policy and procedures are in place for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an	**5/13/2025**

	irregularity that requires urgent action to protect the resident. The facility will timely address the pharmacy recommendations according to the facility policy and procedure. The Pharmacy recommendations will be signed, completed and acted on within 30 days of being sent to the facility. Resident #157 continues to reside comfortably in the Community and receive care per physicians' orders and plan of care. His/Her physician was contacted immediately to address the pharmacy recommendation. The order in question was clarified and a new order were obtained. Resident #16 continues to reside comfortably in the Community and receive care per physicians' orders and plan of care. His/Her physician was contacted immediately to address the pharmacy recommendation at which time new orders were obtained. Pharmacy recommendations for March were reviewed by DON/designee, physicians were notified if needed and intervention implemented as indicated by physician. The Director of Nursing and /or designee will complete education for all nurses on the Community's Pharmacy recommendation policy and procedures. New licensed nurse employees will be educated on the Community's Pharmacy recommendation policy and procedures during new employee orientation. Ongoing education will be provided to licensed nurses yearly and as needed. The DON and/or designee will review the summary of Pharmacy recommendations monthly and review at random 20 recommendations for accurate completion within the 30-day timeframe. Any Incomplete recommendations will be addressed at the time of discovery. Audits will continue for 12 weeks.	

	Compliance findings will be discussed monthly by DON/Designee during QAA Committee Meeting monthly for three months.	
F759	The Community will continue to ensure that its medication error rate is not 5 percent or greater and residents are free of significant medication errors. The Community will continue to ensure safe administration of insulin via pen devices according to physician orders and facility policy and procedures. The Community Immediately in-serviced Nurses on facility Insulin Administration policy and procedure. Resident #67 continues to reside comfortably in the community and receives care following physicians' orders and plan of care. He/She did not exhibit any adverse effects following insulin administration on 4-8-2025. He/she ate 2 bowls of oatmeal for breakfast and did not complain about his/her stomach hurting after breakfast. His/her blood sugar at lunch was 160. Resident #112, #157 & #141 continue to reside comfortably in the community and receive care following physicians' orders and plan of care. He/she did not present with adverse effects from the insulin administration on the date of the observation. Resident #141 Resident's physician has been notified regarding insulin dose administered; no new orders were obtained. The Director of Nursing and /or designee will continue education for all licensed nurses on the Community's Policy and Procedure for Insulin Administration via pen device including education on verifying dose, priming the insulin pen needle and for Insulin being given at the correct time in relation to meals. New licensed nursing employees will be educated on the Community's Insulin Administration via pen device policy and procedure which includes verifying dose, priming the insulin pen needle and Insulin being given at the correct time in relation to meals. Ongoing education will be provided to staff yearly and as needed.	**5/13/2025**

	The DON and/or designee will conduct random observations of 4 residents Insulin administration per week to ensure proper administration per the Community's policy. Audits will continue for 12 weeks. Compliance findings will be discussed monthly by DON/Designee during QAA Committee Meeting monthly for three months.	
F761	The Community will continue to ensure labeling of Drugs and Biologicals Drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In addition, the community will store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The community will also ensure and provide permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the community uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. The community will ensure drugs and biologicals are stored in accordance with acceptable standards of practice The facility will ensure staff double-lock the refrigerated controlled medications. The 2 areas noted in the surveyor's observations were identified and corrected the day observed. The Community's five medication rooms were audited by the Assistant Director of Nursing and currently have Schedule II Control medications stored with a double lock system. ADON and/or designee immediately re-educated the Community's licensed nurses regarding the facility Policy for the Storage of Drugs using a double-lock system. The Director of Nursing and /or designee will complete education for all licensed nurses on the	**5/13/2025**

	Community's Policy regarding Drug Storage of Schedule II Control medications. New licensed nurse employees will be educated on the Community's Policy regarding Drug Storage for Schedule II Control medications during new employee orientation. Ongoing education will be provided to licensed nurses yearly and as needed. The DON and/or designee will complete random, routine observations and monitor compliance to ensure the facility is compliant with the locked storage of refrigerated Schedule II Control medications per facility policy weekly. Any noted infractions will be addressed at the time of discovery. Audits will continue for 12 weeks. Compliance findings will be discussed monthly by DON/Designee during QAA Committee Meeting monthly for three months and then as indicated by QAA Committee.	
F812	The facility will continue to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Staff were in-serviced immediately during the annual survey by the DSD (Dining Services Director) on the proper reading and recording of dish machine temperatures, cleaning of equipment and following recipes for Pureed foods. All Dietary staff will be in-serviced by the Dining Service Director (DSD) and/or Registered Dietitian (RD) on all items listed below: 1. The proper recording of the dish machine temperatures at each meal and recording the concentration of the sanitizer throughout each day. 2. The proper cleaning of all equipment, including stove, deep fryer, grill, ovens and in-between all equipment. 3. The importance of covering, labeling and dating all items to keep from being exposed to air, including boxes of sausage and bacon.	**5/13/2025**

	4. The importance of reading the expiration dates on products when putting away stock and disposing of any outdated items. 5. The importance of following Pureed recipes for consistency, texture, taste, and proper nutrition and the importance of the proper cleaning of the food processor between different food items. All new staff will be in-serviced on the above noted items by the DSD and/or designee during orientation. The DSD/designee will monitor for compliance on the cited items on a weekly basis for 12 weeks and report findings at the monthly QA meetings.	
F880	The Community will continue to provide an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the spread of infection. Resident #424 no longer resides in the Community. Resident #22 continues to reside in the Community and receive care according to physician's orders and care plan. The RN Educator/Designee has and will continue to re-in-service direct care staff on the Community's Infection Control Policy to include guidance for when to implement contact isolation and proper use of Personal Protective Equipment (PPE) as well as proper use of Enhanced Barrier Precautions (EBP) during provision of high contact care for high-risk residents. In addition, the RN Educator/designee will continue to educate new employees on the Community's Infection Control Policies including the type of isolation, use of PPE and EBP guidelines during new employee orientation and ongoing with care givers as indicated by direct care observations. Resident #67 continues to reside in the Community and receive care according to physician's orders and care plan.	**5/13/2025**

	The Director of Nursing/Designee immediately provided education to LPN D and the licensed nursing staff on the Community's Insulin Administration Policy Via Pen on (date) as a result of the surveyor's observations. The RN Educator/Designee will continue to educate new licensed nurses on the Community's Insulin Administration Policy during new employee orientation and ongoing as indicated by direct care observations. Resident #112, #157, #32, and #141 continues to reside in the Community and receive care according to physician's orders and care plan. The RN Educator/Designee has and will continue to re-in-service licensed nurses on the Community's Infection Control Policy to include cleaning of shared equipment with approved cleansing products between each resident use. The RN Educator/Designee will continue to educate new licensed nurses on the Community's Cleaning of Shared Equipment Policy during new employee orientation and ongoing as indicated by direct care observations. Resident #57 continues to reside in the Community and receive care according to physician's orders and care plan. The RN Educator/Designee has and will continue to re-in-service licensed and certified staff that administer medications on the Community's Medication Administration Policy. The RN Educator/Designee will continue to educate new licensed and certified staff that may pass medications on the Community's Medication Administration Policy during new employee orientation and ongoing as indicated by direct care observations. The RN Educator/Designee has and will continue to re-in-service laundry personal on covering linen when transporting through the building by 5/13/25. The RN Educator/Designee will continue to educate new laundry staff on covering linen when transporting	

	through the building during new employee orientation and ongoing as indicated by direct care observations. The Director of Nursing/Designee will conduct 3 random, direct care observations of staff providing high contact care during routine rounds to ensure proper use PPE for residents on isolation and/or EBP if needed, weekly for 12 weeks. Any noted infractions will be addressed at the time of discovery. All findings will be reported by the DON to the Quality Assurance Committee monthly. The Director of Nursing/designee will conduct 3 random, direct care observations of licensed nurses during routine rounds ensuring use of approved cleansing products during cleaning of shared equipment and administration of insulin via pen, weekly for 12 weeks. Any noted infractions will be addressed at the time of discovery. All findings will be reported by the DON to the Quality Assurance Committee monthly. The Director of Nursing/designee will conduct 3 random, direct care observations of certified staff that pass medications during routine rounds ensuring proper infection control practices are used during medication passes, weekly for 12 weeks. Any noted infractions will be addressed at the time of discovery. All findings will be reported by the DON to the Quality Assurance Committee monthly. The Director of Nursing/designee will conduct 3 random, direct care observations of laundry personnel to ensure linen is covered when transporting through the building, weekly for 12 weeks. Any noted infractions will be addressed at the time of discovery. All findings will be reported by the DON to the Quality Assurance Committee monthly.	
	The Community understands the importance of keeping all means of egress free from obstructions in case of emergency. The Community will make alterations to the physical plant to meet – Means of Egress – General NFPA 101 (2012)	

A4055	19 CSR30-85.042(46) Safe/Effective Medication System	**5/13/2025**

	See the POC for F759	
A4061	19 CSR 30-85.042(52) Drug Regimen Review-Monthly See the POC for F756	**5/13/2025**
A4065	19 CSR 30-85.0042(56) Schedule II Meds-Storage See the POC for F761	**5/13/2025**
A4074	19 CSR 30-85.042(65) Protective Oversight, Voluntary Leave See POC for F689	**5/13/2025**
A4075	19 CSR 30-85.42(66) Nursing Care Per Res Condition See POC for F694	**5/13/2025**
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease See POC for F880	**5/13/2025**
A5004	19 CSR 30-85.052(4) Food Texture-Chewing Difficulty See POC for F812	**5/13/2025**
A6025	19 CSR 30-87.020(25) Plumbing per Code See POC for F584	**5/13/2025**
A7015	19 CSR 30-87.030(13) Food-Protected, Temp, Need to Contact DHSS See POC for F812	**5/13/2025**
A7019	19 CSR 30-87.030(17) Food Stored in Identifying Containers See POC for F812	**5/13/2025**
A7056	19 CSR 30-87.030(54) Nonfood Contact Surfaces, Cleaning See POC for F812	**5/13/2025**
A7065	19 CSR 30-87.030(63) Food-Contact Surfaces Washed/Rinsed/Sanitizer See POC for F812	**5/13/2025**
A7077	19 CSR 30-87.030(75) Dishwashing Machine Types See POC for F812	**5/13/2025**

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.