

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2025
NAME OF PROVIDER OR SUPPLIER Delmar Gardens of Creve Coeur		STREET ADDRESS, CITY, STATE, ZIP CODE 850 Country Manor Lane Creve Coeur, MO 63141	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff treated residents with dignity and respect when a staff member took a video of a resident from a personal phone and posted in social media (Resident #39). In addition, staff used their personal phones while monitoring residents during mealtime. The census was 94. The sample was 22.</p> <p>Review of the facility's undated Resident Rights, showed:</p> <p>-Your right to be treated with dignity and respect is the foundation of which all other resident rights and responsibility are based;</p> <p>-Your right to privacy and confidentiality is as important to you as it is to any other person.</p> <p>Review of the facility's Social Media and Electronic Devices Policy, dated 11/2019, showed:</p> <p>-To ensure residents receive the highest quality of care and to minimize risks associated with the use of social media and electronic devices in healthcare, the facility expects its employees to adhere to the guidelines and rules outlined in this policy;</p> <p>-Employees are strictly prohibited from posting, uploading, sending, or otherwise sharing or disclosing photos, videos or personal information of any resident without prior written permission of the resident or the resident's authorized agent;</p> <p>-Employees must use the facility's authorization form to obtain such prior written permission. This prohibition includes photos, videos, or other postings where the resident is not easily identifiable (e.g., a photo of the resident's hand, a close up photo of any part of a resident's body, or a photo of the back of a resident in the far background of the photo).</p> <p>-Employees are prohibited from having personal cell phones, smartphones, or digital cameras while working with or near residents, resident charts or other medical documents, white boards containing resident information, or resident medications. Additionally, employees are prohibited from using an electronic device with camera, video, and audio capabilities to record conversations or actions of anyone in the facility, including other employees.</p> <p>1. Review of Resident #39's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed:</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-admitted on [DATE];</p> <p>-Severely impaired cognitive skills for daily decision-making;</p> <p>-Diagnoses included heart disease, diabetes, dementia and anxiety;</p> <p>-On hospice care.</p> <p>Review of the resident's care plan, in use at time of survey, showed:</p> <p>-Problem: Behavioral symptoms. Resident at risk for harm related to the behavior, has inattention and disorganized thinking, elopement risk, looking for his/her care, talks out loudly and yells 'help' a lot;</p> <p>-Goal: Resident will be safe and free from harm to self and others and decreased in behavior through next review;</p> <p>-Approach: Assess and document behaviors as they occur, treat him/her with respect;</p> <p>-Problem: Cognitive loss/dementia;</p> <p>-Goal: Resident will have positive experiences in daily routine without overly demanding tasks and without becoming overly stressed through next review;</p> <p>-Approach: Encourage to verbalize feelings, concerns and fears, clarify misconceptions. Respect the resident's rights to make decisions. Support and reassure the resident in new situations.</p> <p>Review of a video clip posted on TikTok (a social media platform for creating, sharing and discovering short videos), by Licensed Practical Nurse (LPN) D, showed a resident sat in a wheelchair propelled by another staff. The eight second video showed the staff pointed the camera mostly to the floor. He/She walked towards the resident who was moved away from a door by the other staff. The side of the resident's face and body was shown very quickly, while the rest of his/her body showed most of the duration of the video. The resident was not easily identifiable, though the facility's floor indicated the facility's unique carpet design.</p> <p>During an interview on [DATE] at approximately 8:15 A.M., the Administrator said he did not recall a report where a staff posted a video on social media involving a resident but would find out if there was anything on file. At 9:20 A.M., the Administrator said the Director of Nursing (DON) had investigated the incident, but it was not proven where and when it occurred, and there was no resident identified.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 9:30 A.M., LPN D said he/she took the video around [DATE]. The resident in the video was Resident #39, who expired about a week ago. LPN D said he/she had no reason for taking the video, he/she was just tired. The video was taken down when he/she realized it was not appropriate. He/She said per the facility's policy, staff were not allowed to take or post video because of HIPAA (Health Insurance Portability and Accountability Act, is a US federal law that protects sensitive patient health information from being disclosed without the patient's consent or knowledge). The DON educated him/her on it. LPN D said the incident was sent to the Corporate office but was determined to not be concerning due to the resident's name was not disclosed.</p> <p>During an interview on [DATE] at 9:54 A.M., the DON said the TikTok video involving LPN D and Resident #39 was brought to her attention by another staff. The DON was unable to recall the staff member's name. The DON could not find a documented investigation, education or in-services following the incident. She discussed the issue with LPN D and instructed him/her to take down the video, which was already done prior to their conversation. She reminded LPN D he/she could not do it without the resident's permission. The DON said LPN D continued to work and stayed on his/her schedule after their discussion. The DON said staff were not allowed to use their cell phones while at work. The staff signed the cellphone usage policy during onboarding orientation.</p> <p>2. Observations on [DATE] of the breakfast meal service in the main dining room showed:</p> <p>-At 8:17 A.M., Certified Nurse Aide (CNA) G at a table with three residents. He/She leaned back in his/her chair and took out his/her phone and began to scroll through his/her phone;</p> <p>-At 8:18 A.M., LPN D sat at a table alone, pulled his/her phone out and scrolled through his/her phone while eating grapes;</p> <p>-At 8:20 A.M., LPN D appeared to type something on his/her phone;</p> <p>-At 8:21 A.M., the Assistant Administrator said something to LPN D and he/she stopped scrolling through his/her phone;</p> <p>-At 8:22 A.M., another staff said something to LPN D. He/She then stood up from the table and placed the phone in his/her pocket;</p> <p>-At 8:23 A.M., CNA G continued to scroll through his/her phone;</p> <p>-At 8:24 A.M., CNA G got up and assisted a resident.</p> <p>During an observation and interview on [DATE] at 11:16 A.M., CNA G was sitting at the Hall 100 nurses' station. Two residents sat in wheelchairs and were parked facing the station. CNA G said he/she was currently on break so he/she could use his/her cellphone. He/She had not observed other staff on cellphones while providing residents' care.</p> <p>During an interview on [DATE] at 11:19 A.M., Housekeeper H said he/she never used his/her cellphone while working and while at the residents' areas. Housekeeper H kept his/her cellphone in his/her pocket at all times.</p> <p>(continued on next page)</p>		

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