STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365313	A. BUILDING _____ B. WING _____	**09/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIDGEPORT HEALTH CARE CENTER	**2125 ROYCE STREET PORTSMOUTH, OH 45662**

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)
F 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, Self-Reported Incident review and policy and procedure review, the facility failed to ensure Resident #53 was treated with respect and dignity, when a Former State tested Nursing Assistant (FSTNA) videoed the resident and sent the recording to another individual not employed by the facility. This affected one resident (#53) of one resident reviewed for dignity and respect. Finding include: Review of the medical record for Resident #53 revealed an admission date of [DATE] with the admitting [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 08/08/20 revealed the resident usually understood others, made himself understood and had a severe cognitive deficit as indicated by a Brief Interview for Mental Status (BIMS) score of two. The resident required limited assistance from staff for transfers and supervision with ambulation. Review of a nursing progress note, dated 09/18/20 at 10:00 A.M. and authored by Registered Nurse (RN) #100 revealed the facility received an anonymous call that an employee took a video of Resident #53. An investigation was initiated. The resident's physician and wife were notified of the incident. The entry also documented the facility contacted the local police department and spoke with an officer. The resident was question but was unable to recall the incident. A plan of care, initiated 09/18/20 indicated the resident had a psychosocial well-being problem related to humiliation related to the resident being a victim of emotional abuse and misappropriation (violation) of resident rights. Interventions included to monitor/document residents feelings, provide assistance/supervision/support to identify causative and contributing factors and when conflict arises, remove residents to a calm safe environment and allow vent/share feelings. Review of a facility self reported incident (SRI), dated 09/18/20 and timed 1:06 P.M. revealed the facility reported an incident of misappropriation related to images of Resident #53. The SRI noted the Administrator was notified on Friday, 09/18/20 via an anonymous phone call FSTNA had taken a video of Resident #53. The FSTNA was notified she needed to come to the facility to provide a statement regarding the allegation. The Administrator asked the FSTNA if she had taken a photo or video of a resident during her shift on 09/17/20 and the FSTNA replied, yes. The Administrator asked the FSTNA if he could view her phone where she showed him one video of Resident #53 shaking his hands as if he won a prize and another video of the resident holding her hand. The FSTNA was asked to identify the resident because the resident was not identifiable in either video. The FSTNA identified the resident as Resident #53. Review of the FSTNA's statement, dated 09/18/20 revealed she was covering the secure care unit for another STNA's lunch break. She said she did video one resident and sent it to a friend (not employed with the facility). The FSTNA denied posting the video to any social media sites. She documented she videoed Resident #53 twice. One video was him grabbing both of his hands, squeezing saying, this is a winner. The other video content was the resident talking about gambling. On 09/24/20 at 11:40 A.M. interview with the Administrator verified the FSTNA videoed Resident #53 and sent the video to another individual not employed with the facility. Review of facility policy titled Disclosure of Resident Images, dated 08/12/20 revealed it was the policy of the facility that inhibited employees from taking photos and/or distributing photographs in any fashion, including but not limited to posting on social media sites or videos that demean or humiliate a resident. This deficiency substantiates Complaint Number OH 957.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.