STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365865	A. BUILDING _____ B. WING _____	08/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAIN STREET CARE CENTER	500 COMMUNITY DRIVE AVON LAKE, OH 44012

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 0583 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, review of a facility Self-Reported Incident (SRI), staff interviews, interviews with local law enforcement, review of the news media release, review of the local police report, observation of the live photographic images, and review of the employee handbook on personal cellphone use, the facility failed to ensure cognitively impaired and cognitively intact residents rights to privacy and confidentiality were maintained by a facility staff member during provision of personal care. This resulted in Immediate Jeopardy and the potential for psychosocial harm for 13 Residents (#58, #59, #60, #63,#64, #67, #70, #71,#72, #74, #79,#80 and #81) when State tested Nurse Aide (STNA) #08 engaged in acts meant to humiliate and dehumanize the residents by taking unauthorized and inappropriate photos on her personal cellular device without permission and not in accordance with facility policy. The photos taken included residents that were nude, lying on the floor, in their beds, and on the toilet. The photos were then shared to a group text chat with three other facility staff (STNA #10, Licensed Practical Nurse (LPN) #09 and LPN #11) for the purpose of what the involved staff stated was communication, resulting in outcomes which one would expect a reasonable person in a similar situation to suffer, subsequently treating the resident as an inanimate object having no emotions or feelings and causing embarrassment and shame for the resident. This affected 13 residents (#58, #59, #60, #63, #64, #67, #70, #71, #72, #74, #79, #80 and #81) able to be identified in the photos of 21 who resided on the dementia unit. The facility identified 11 residents (#59, #60, #63, #64, #67, #70, #71, #74, #79, #80 and #81) of the 13 had severely impaired cognition and were unable to speak for themselves. There was a total of 25 images of residents on her personal phone. The facility census was 79. On [DATE] at 10:00 A.M., the facilities Administrator and Corporate Vice President #100 were notified that Immediate Jeopardy began on [DATE] when during an unrelated police investigation on [DATE], it was discovered that STNA #08 had taken unauthorized disturbing photos of residents nude in bed, walking around partially nude, lying in bed in gowns, tipped over in wheelchairs, partially nude shaking fists toward the camera, and then shared them in a group text message with co-workers (STNA #10, LPN #09 and LPN #11). The Immediate Jeopardy was removed on [DATE] when staff education was provided regarding the identification of abuse, the abuse policy and procedures, maintaining the residents' rights to privacy and confidentiality during the provision of personal care and utilization of cellular phones and/or photographing mobile devices. Additionally, head-to-toe assessments were completed on all the residents who resided on the dementia unit and residents able to make their needs known were interviewed. The deficiency remained at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) until it was corrected on [DATE] when the facility implemented the following: On [DATE] at approximately 4:30 P.M., the Administrator and Director of Nursing (DON) viewed the photos on STNA #08's phone. They identified 13 Residents (#58, #59, #60, #63, #64, #67, #70, #71, #72, #74, #79, #80 and #81) in the photos. On [DATE] at 5:00 P.M., the Administrator and DON suspended STNAs #08 and #10 and LPNs #09 and #11 pending the outcome of the investigation. On [DATE] between 5:00 P.M. and 8:00 P.M., the DON completed head-to-toe assessments on all residents who resided on the dementia unit (primary unit where STNA #08 and other involved staff members worked) with no negative findings. On [DATE] at 5:00 P.M., the Administrator and DON in-serviced current staff working on its abuse policy and cellphone use policy and completed staff interviews regarding the incident. Staff interviewed denied knowledge of the situation and similar situations occurring at the facility. Staff who were not working were called and all staff were in-serviced and acknowledged receipt of training and had no knowledge of the incident by [DATE]. On [DATE] at 9:00 A.M., the Administrator notified all residents and/or their responsible parties who were noted in the photos. On [DATE], the Administrator and DON drafted an audit tool to monitor personal cell phone usage within the facility. The audits began on [DATE] by the Administrator and the DON. Monitoring will continue on three to four halls per week for four weeks, then randomly thereafter for a total of four months. On [DATE] between 10:00 A.M. and 12:00 P.M., the DON interviewed Residents #58 and #72 (no other residents involved in the incident were able to be interviewed due to severe cognitive impairment) regarding the incident. Both residents reported feeling safe at the facility and had no concerns related to the incident. On [DATE] between 8:00 A.M. and 5:00 P.M., the DON interviewed a random sample of residents (#09, #10, #13, #15, #16, #29, #39 and #54) who did not reside on the dementia unit with the staff involved in the incidents. All residents stated they felt safe at the facility and had never had any unauthorized photos taken. On [DATE], the Administrator terminated STNA's #08 and #10 and LPN's #09 and #11 employment from the facility. On [DATE] at 5:38 P.M., the Administrator drafted a letter and sent to all residents and family members notifying them of the incident and the facilities on-going corrective action. Findings Include: 1) Review of the medical record for Resident #58 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the most recent Minimum Data Set (MDS) 3.0 assessment, dated [DATE], revealed the resident had severely impaired cognition. The resident required extensive assistance of two staff for bed mobility, transfers, ambulation and all other Activities of Daily Living (ADL). 2) Review of the medical record for Resident #59 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the most recent MDS 3.0 assessment, dated [DATE], revealed the resident had intact cognition. The resident was independent for bed mobility, transfers, ambulation and all other activities of daily living. 3) Review of the medical record for Resident #60 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the most recent MDS 3.0 assessment, dated [DATE], revealed the resident had severely impaired cognition. The resident required extensive assistance of one staff for bed mobility, transfers, ambulation and all other ADL care. 4) Review of the medical record for Resident #63 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the most recent MDS 3.0 assessment, dated [DATE], revealed the resident had severely impaired cognition. The resident required extensive assistance of two staff for bed mobility, transfers, ambulation and all other ADL care. 5) Review of the medical record for Resident #64 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the most recent MDS 3.0 assessment, dated [DATE], revealed the resident had severely impaired cognition. The resident required extensive assistance of one staff for bed mobility, transfers, ambulation and all other ADL care. 6) Review of the medical record for Resident #67 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the most recent MDS 3.0 assessment, dated [DATE], revealed the resident had severely impaired cognition. The resident required extensive assistance of two staff for bed mobility, transfers, ambulation and all other ADL care. 7) Review of the medical record for Resident #70 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the most recent MDS 3.0 assessment, dated [DATE], revealed the resident had severely impaired cognition. The resident required extensive assistance of two staff for bed mobility, transfers, ambulation and all other ADL care. 8) Review of the medical record for Resident #71 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the most recent MDS 3.0 assessment, dated [DATE], revealed the resident had severely impaired cognition. The resident required extensive assistance of two staff for bed mobility, transfers, ambulation and all other ADL care. 9) Review of the medical record for Resident #72 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the most recent MDS 3.0 assessment, dated [DATE], the resident had intact cognition. The resident required extensive assistance of one staff for bed mobility, transfers,

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.

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F 0583 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) ambulation and all other ADL care. 10) Review of the medical record for Resident #74 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the most recent MDS 3.0 assessment, dated [DATE], revealed the resident had severely impaired cognition. The resident required extensive assistance of one staff for bed mobility, transfers, ambulation and all other ADL care. 11) Review of the medical record for Resident #79 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the most recent MDS 3.0 assessment, dated [DATE], revealed the resident had severely impaired cognition. The resident required extensive assistance of two staff for bed mobility, transfers, ambulation and all other ADL care. 12) Review of the closed medical record for Resident #80 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Resident #80 was discharged to a local hospital on [DATE]. Review of the most recent MDS 3.0 assessment, dated [DATE], revealed the resident had severely impaired cognition. The resident required extensive assistance of two staff for bed mobility, transfers, ambulation and all other ADL care. 13) Review of the closed medical record for Resident #81 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Resident #81 expired at the facility on [DATE]. Review of the most recent MDS 3.0 assessment, dated [DATE], revealed the resident had impaired cognition. The resident required extensive assistance of two staff for bed mobility, transfers, ambulation and all other ADL care. Review of the SRI dated [DATE] and timed 4:19 P.M. revealed on [DATE] the Administrator was notified by local law enforcement of a police investigation which involved STNA #08. Detective #101 discovered unauthorized pictures of residents on STNA #08's personal cellular phone during an unrelated police investigation. The Administrator and the DON were able to identify 13 Residents (#58,#59, #60,#63, #64, #67, #70, #71, #72, #74, #79, #80 and #81) in the 28 photos taken which included residents nude, lying on the floor, in their beds and on the toilet. These photos were then shared to a group text message chat with three other facility staff (STNA #10 and LPNs #09 and #11). Review of the facility investigation completed from [DATE] through [DATE] revealed the Administrator and the DON interviewed STNA #08 on [DATE] at 5:00 P.M. regarding the photos found on her personal cell phone. STNA #08 verified she had taken the unauthorized photos and shared them with STNA #10 and LPNs #09 and #11 as part of a group text message chat to communicate resident needs. Review of the written statements dated [DATE] from STNA #10 and LPNs #09 and #11 verified they had received unauthorized photos on their personal cellular devices. Interview on [DATE] at 9:45 A.M., the Administrator verified the findings of the SRI. Interview on [DATE] at 9:15 A.M., Detective #101 verified an active investigation was currently in progress regarding STNA #08's actions involving taking inappropriate photos of residents who resided in the nursing home where she worked. Telephone interviews were attempted on [DATE] at 12:33 P.M. and [DATE] at 11:08 A.M., with STNA #08, STNA #10, LPN #09 and LPN #11 but were unsuccessful. Messages were left and there was no return contact made. Review of the local news media report dated [DATE] and timed 6:32 P.M. revealed STNA #08 was under investigation by local law enforcement after inappropriate photos of residents were found in her cell phone. Review of the police report dated [DATE] revealed on [DATE] the facilities local police department received a call from another local police department regarding STNA #08. After receiving consent to search STNA #08's phone during an unrelated crime investigation it was discovered STNA #08 had inappropriate photos of elderly persons in her phone. It was later discovered STNA #08 was an employee of a local long-term care facility for the past five years. The local police department began its own investigation and verified that on STNA #08's personal cellular phone were 28 live pictures, 13 of which were of various facility residents in various positions including one resident fully nude and exposed lying in her bed. Observation of the live photo images extracted from STNA #08's phone and verified by the local police department, using longitude and latitude coordinates, revealed the pictures had been taken at the facility and were dated from [DATE] (which was prior to the last annual survey) through [DATE]. Observation of the live photo (Image Number 1176) dated [DATE] at 3:25 A.M., revealed Resident #81 was tipped over backwards in a wheelchair. His legs were up in the air, he was wearing a hospital style gown which came up and had exposed his adult brief. His eyes were open, he was holding his head with his right hand and had a pillow underneath his head. Observation of the live photo (Image Number 1465) dated [DATE] at 9:02 P.M., revealed Resident #74 was wandering around the unit in her underwear holding a blue shirt against her nude torso. Observation of a second live photo (Image Number 2651) on [DATE] at 7:52 P.M., revealed the resident was taking medication. Review of a third live photo (Image Number 8554) on [DATE] at 12:07 P.M., revealed Resident #74 was lying in bed fully clothed with Resident #71 who was also fully clothed. Observation of the live photos (Image Numbers 1515 and 1519) dated [DATE] at 4:46 P.M., and at 5:34 P.M., revealed Resident #71 was walking laps around the dining room. The commentary on the live photo stated, she keeps going around in circles, this is like her fifth time doing it. There were five other unidentified residents captured on the live photo image. Observation of the live photo (Image Number 8555) dated [DATE] at 5:55 P.M., revealed the resident was dancing in her room and the voice on the live photo stated, shake that booty girl, shake that booty. Observation of the live photos (Image Numbers 1685 and 2095) dated [DATE] at 10:31 P.M., and [DATE] at 8:53 A.M., revealed Resident #64 was sitting backwards in an upholstered chair in what appeared to be a common area. Observation of the live photo (Image Number 1760) dated [DATE] at 4:59 P.M., revealed Resident #72 was dancing with what appeared to be an unknown facility staff member and their buttocks were touching doing dance moves. The commentary on the live photo while the dancing took place stated shake it ooh, ooh, ooh, ooh laughter was also heard in the background. Observation of the live photo (Image Number 1796) dated [DATE] at 1:20 A.M., revealed Resident #80 was sitting in a chair in a common area only wearing his underwear and socks. Observation of a second live photo (Image Number 2307) revealed the resident was sitting in a wheelchair fully clothed. Observation of the live photo (Image Number 2084) dated [DATE] at 9:09 P.M., revealed Resident #63 was sitting up in her wheelchair kicking her foot and the bedside table was tipped over on the floor. Observation of a second live photo (Image Number 2419) dated [DATE] at 7:08 P.M., revealed Resident #63 was lying nude in bed on her buttocks, resting on her left elbow facing the photographer. The resident was wearing only one sock on her left foot and her breasts and peri area were exposed. During the live photo, the resident reached her right arm across her body toward the photographer. Observation of a third live photo (Image Number 0982) dated [DATE] at 6:16 P.M. revealed the resident was lying in bed on her right side wearing a hospital gown and her left hip and buttocks were exposed. Observation of the live photo (Image Number 2052) dated [DATE] at 1:58 P.M., revealed Resident #58 was sitting up on the side of the bed wearing a hospital gown. Observation of the live photo (Image Number 2286) dated [DATE] at 5:23 P.M., revealed Resident #60 was walking toward the camera mumbling loudly and shaking her fists at eye level. The resident was wearing a shirt and an adult brief. Observation of a second photo (Image Number 2363) dated [DATE] at 12:10 P.M. revealed the resident was sitting on a toilet fully clothed. Observation of the live photo (Image Number 0873) dated [DATE] at 8:38 P.M., revealed Resident #70 was lying on the floor near a doorway in front of a high back wheelchair wearing plaid pajamas mumbling. Observation of the live photo (Image Number 0983) dated [DATE] at 6:19 P.M., revealed Resident #59 was in bed with the head of the bed elevated, she had a bedside tray across the bed with an uneaten meal tray and liquid spilled across the bedside table. The resident was wearing a hospital gown and was slumped over to the right side of the bed with a furrowed brow and facial grimacing. Observation of the live photo (Image Number 0984) dated [DATE] at 6:20 P.M., revealed Resident #67 was lying in bed covered with a blanket with her eye closed. Observation of the live photo (Image Number 0985) dated [DATE] at 6:21 P.M., revealed Resident #79 was lying in bed covered with a blanket with eyes closed and mouth open. Review of the employee handbook section titled Do not take pictures, videos or recordings of residents or disclose residents' protected health information dated [DATE] revealed employees are instructed under no circumstances to take pictures, videos or recordings of residents or disclose residents' protected health information (PHI). This deficiency substantiates Complaint Number OH 778.