STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366327	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GLENDALE PLACE CARE CENTER	779 GLENDALE MILFORD ROAD CINCINNATI, OH 45215

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, personnel record, a facility Self-Reported Incident (SRI), witness statements, employee timecard, a social media video post, the facility's Abuse, Neglect and Exploitation policy, the facility's Social Media policy, a police report and staff interviews, the facility failed to ensure one cognitively impaired resident (Resident #20) was free from potential mental and emotional abuse by facility staff. This resulted in Immediate Jeopardy and the potential for psychosocial harm for one resident (Resident #20) when State tested Nurse Aide (STNA) #01 took a video of herself combing Resident #20's hair. STNA #01 and Resident #20 had a verbal exchange, including expletive words. Resident #20 attempted to pull the comb away from the STNA while she provided care. STNA #01 posted the video on Snap Chat (a Social Media Website) without the resident's consent, and the video was reposted to Facebook (another Social Media Website) by an unidentified person. Applying the reasonable person concept to the incident, could potentially result in the person feeling humiliated, demeaned and exploited due to being posted on Social Media Websites for others to view. This affected one of three residents reviewed for abuse. On 06/29/20 at 3:00 P.M., the Administrator, the Director of Nursing (DON) and Corporate Registered Nurse (RN) #02 were notified that Immediate Jeopardy began on 06/24/20 when STNA #01 took a video of herself combing Resident #20's hair. Review of the video revealed STNA #01 and Resident #20 had a verbal exchange, including expletive words. Resident #20 attempted to pull the comb away from the STNA while she provided care. Resident #20 was observed to be agitated and upset during the incident and cursed at the STNA. The Immediate Jeopardy was removed on 06/25/20 when the facility implemented the following corrective actions: On 06/24/20 at 4:10 P.M., Admissions Coordinator #04 informed Licensed Practical Nurse (LPN) Supervisor #03 of a video of a resident (Resident #20) being posted on social media. On 06/24/20 at 4:13 P.M., the Administrator and the DON received notification from LPN Supervisor #03 of the video. The Administrator and the DON initiated an internal investigation involving the video. The DON notified Resident #20's family of the video being posted on social media. On 06/24/20 at 4:15 PM, the facility began obtaining statements from staff interviews. All staff statements were obtained by 06/25/20 at 9:00 A.M. On 06/24/20 at 4:16 P.M., STNA #01 was suspended and asked to leave the facility. LPN Supervisor #03 assessed Resident #20 with no injuries noted. On 06/24/20 from 4:19 P.M. to 4:40 P.M., the Administrator spoke with Social Media Consultant #05 and gathered further details of the video. On 06/24/20 at 4:23 P.M., the DON notified Medical Director #07 and Physician #06 of the incident. On 06/24/20 at 4:30 P.M., LPN Supervisor #03 initiated education on the Health Insurance Portability and Accountability Act (HIPAA) and the abuse, neglect, the social media and resident rights policies. On 06/24/20 at 4:45 P.M., the Administrator contacted Admissions Coordinator #04 for her witness statement and at that time provided education on HIPAA and the abuse, neglect, social media and resident rights policies. On 06/24/20 at 4:51 P.M., the Administrator began educating administrative employees on HIPAA and the abuse, neglect, social media and resident rights policies. On 06/24/20 at 4:56 P.M., the DON began educating nurses and STNAs on HIPAA and the abuse, neglect, social media and resident rights policies. On 06/24/20 at 6:46 P.M., the Administrator submitted an SRI regarding the incident. The Administrator attempted to submit the SRI from 5:23 P.M. to 6:23 P.M. but had issues with the online system. On 06/24/20 at 8:23 P.M., LPN #15 assessed Resident #20 for injuries with no negative findings. On 06/24/20 at 9:29 P.M., LPN Supervisor #03, RN Supervisor #12 and STNA #10 interviewed and assessed Residents #17, #18, #19, #20, #21 and #22 who were assigned to STNA #01 with no negative findings. On 06/24/20 from 8:24 P.M. to 9:34 P.M., the Administrator provided education to non-nursing employees about HIPAA and the abuse, neglect, social media and resident rights policies. On 06/25/20 from 6:15 A.M. to 11:00 A.M., the Administrator provided re-education to all employees at the beginning and end of their shift about HIPAA and the abuse, neglect, social media and resident rights policies. On 06/25/20 at 6:56 A.M., LPN #55 reassessed Resident #20 for injuries with no negative findings. On 06/25/20 at 8:00 A.M., Social Services Director (SSD) #16 re-interviewed Resident #20 with no negative findings. On 06/25/20 at 8:00 A.M., the DON initiated resident interviews and assessments for cognitively impaired residents with no negative findings. On 06/25/20 at 9:00 A.M., the DON implemented an audit tool to include: SSD and/or designee will complete random resident interviews three to five times a week for four weeks regarding resident's safety from abuse/neglect, resident rights violations and/or HIPAA concerns. Monitoring and any issues identified will be addressed and reviewed in the Quality Assurance and Performance Improvement (QAPI) committee meeting. The DON and/or designee will complete random resident observations of grooming care three times a week for four weeks to monitor staff approach with care. Monitoring and any issues identified will be addressed and reviewed by the QAPI committee. On 06/25/20 at 9:05 A.M., the QAPI plan was initiated and the plan of correction, education and audits were reviewed by the DON and Social Services #56. On 06/25/20 at 9:30 A.M., SSD #16 contacted Psychologist #13 to set up a telehealth visit for Resident #20. This occurred on the same day with no negative findings. On 06/25/20 at 10:06 A.M., the Administrator notified the local Police Department of the incident and a report was filed. On 06/25/20 at 11:45 A.M., the DON, LPN Supervisor #03, RN Supervisor #12 and STNA #10 completed resident interviews and assessments. There were no negative findings. On 06/25/20, the Administrator and the DON terminated STNA #01 from employment at the facility. STNA #01's disciplinary action form indicated STNA #01 posted a live video of herself on social media providing care to a resident who had a [DIAGNOSES REDACTED].#01 brushing the resident's hair. The resident was waving her arms and grabbing her own hair telling STNA #01 to stop and calling STNA #01 names. STNA #01 responded to the resident and did not stop combing her hair during the duration of the video. The video lasted for 40 seconds. The termination was completed by telephone. Although the Immediate Jeopardy was removed, the deficiency remained at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and were monitoring to ensure on-going compliance. Findings include: Medical record review revealed Resident #20 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was severely cognitively impaired and required extensive assistance with bed mobility, transfers, toileting and dressing. Resident #20 required total dependence with personal hygiene. Resident #20 was admitted to hospice on 06/01/20 for late [MEDICAL CONDITION] disease with dementia. Review of Resident #20's nurses progress notes dated 06/24/20 at 4:00 P.M. revealed the resident had a head to toe total assessment with no injuries noted. Resident #20 also had a head to toe total assessment on 06/24/20 at 7:36 P.M. with no tenderness, bumps or [MEDICAL CONDITION] noted to the scalp. No bruising was noted and Resident #20's skin was intact. The resident reported no complaints of pain. Review of Resident #20's geropsychiatry consultation dated 06/25/20 revealed the resident showed no signs of distress either physically or emotionally. Review of the undated social media video revealed STNA #01 was combing Resident #20's hair. STNA #01 stated girl bye and Resident #20 called STNA #01 an expletive. STNA #01 stated, Oh, I'm an expletive and she continued to comb Resident #20's hair. Resident #20 grabbed toward the comb and then clapped

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) her hands together. STNA #01 stated Stop playing bro. You're not going to hit nothing. Resident #20 grabbed towards the comb again and STNA #01 stated, Stop playing and called the resident by her first name. STNA #01 also stated Girl your hair nappy so you're going to have to chill out. Review of the facility's SRI dated 06/24/20 revealed on 06/24/20, STNA #01 posted a live video of herself combing Resident #20's hair. A person in the community notified the facility through the facility's website in the form of private messenger of the video. STNA #01 was immediately removed from facility and placed on suspension and the employee's file was reviewed. Resident #20 was immediately assessed with [REDACTED]. The facility continued to coordinate the investigation with involvement of the medical director, family and the local police department. Social Services interviewed the resident and the resident was not able to recall details associated with the situation. The resident was noted to have cognitive impairment. Residents on the same unit were also interviewed with no concerns voiced. The facility substantiated the allegation due to the employees' individual action. STNA #01 was contacted by the Administrator, Human Resources and the DON on 6/25/20. STNA #01 stated she did not harm the resident. STNA #01 stated she posted the video with no motive and it was a joke. STNA #01 stated sometimes this resident puts her hands up and curses at staff during care. The employee was terminated. Education was completed on 06/24/20 and 06/25/20 with current employees. The facility coordinated with the psychologist for telecare on 06/25/20 without any residual effects identified related to the situation. The SRI reported the facility would continue random interviews with current residents residing in the facility three to five times a week for four weeks in regards to resident's safety from abuse, neglect, resident rights violations and HIPAA concerns. Interviews were initiated on 6/25/20. Monitoring and any issues identified with staffing would be addressed and reviewed in the QAPI committee. The SRI also indicated the local police were contacted on 06/25/20. The local police reviewed the incident and Police Officer #100 stated the incident was not abuse and no criminal charges would be filed. Police Officer #100 reported this was a procedural issue and suggested the facility report the STNA to the medical board if necessary. Review of the facility's timeline (that was included with the SRI) dated 06/24/20 revealed on 06/24/20 at 3:46 P.M., STNA #01 posted the video on SnapChat, on 06/24/20 at 4:10 P.M., LPN Supervisor #03 was made aware of the posting on social media, on 06/24/20 at 4:14 P.M., the DON and the Administrator were notified of the concern, on 06/24/20 at 4:16 P.M., Resident #20 was assessed with [REDACTED].#01 was pulled from the floor and suspended, on 06/24/20 at 4:20 P.M., STNA #01 was asked to leave the facility and on 06/24/20 at 4:29 P.M., STNA #01 punched out at the time clock. Review of Admissions Coordinator #04's witness statement dated 06/24/20 revealed she saw a notification on messenger for the facility's Facebook. Admissions Coordinator #04 read the message and started to watch the video. Admissions Coordinator #04 stopped the video and asked LPN Supervisor #03 to come to her office. LPN Supervisor #03 came to the office and watched the video with her. LPN Supervisor #03 immediately called the DON. Review of LPN Supervisor #03's witness statement dated 06/25/20 revealed on 06/24/20 at around 4:00 P.M., LPN Supervisor #03 was informed there was a video placed on social media by STNA #01 and it included Resident #20. LPN Supervisor #03 notified the DON and the Administrator immediately. The DON informed LPN Supervisor #03 to remove STNA #01 from the premises immediately and inform her that she was not able to return to the facility until she had spoken to the DON. LPN Supervisor #03 asked LPN #15 to complete a head to toe assessment on Resident #20, the resident had no injuries. Review of STNA #01's timecard revealed STNA #01 clocked in at the facility on 06/24/20 at 6:59 A.M. and clocked out at the facility on 06/24/20 at 4:29 P.M. Telephone interview with the Administrator on 6/25/20 at 4:19 P.M. revealed STNA #01 took a live video of herself combing Resident #20's hair and posted it on Snap Chat. The Administrator stated someone from Snap Chat saved the video and put it on Facebook. The Administrator stated the facility was made aware of the incident when an unidentified person from the community contacted them through Facebook messenger and informed them of the video. The Administrator reported the facility did not know how the unidentified person knew it was a resident of the facility in the video. The Administrator stated the facility investigated the incident and spoke with STNA #01. STNA #01 stated she was not harming Resident #20 or doing anything to hurt Resident #20. She states she posted the video as a joke. The Administrator stated STNA #01 was terminated on 06/25/20 but she was suspended immediately. Telephone interview on 06/29/20 at 11:21 A.M. with STNA #01 revealed STNA #01 videotaped herself providing care to Resident #20 in the resident's restroom. STNA #01 reported she did not remember the exact date that she took the video. STNA #01 stated that Resident #20 had a history of [REDACTED]. STNA #01 stated Resident #20 calls everyone expletives and Resident #20 did not want her hair brushed or oral care completed. STNA #01 stated the STNAs had to provide care to the resident because the residents daughter has requested for care to be completed. STNA #01 reported she knew she was not supposed to record any residents. STNA #01 stated she posted the video to her private Snap Chat. STNA #01 reported someone thought the video was funny and they posted it on their page. Someone else took it off the other persons page and posted it on Facebook. STNA #01 reported the video was originally posted on a private story to approximately 10 people that were STNA #01's friends. STNA #01 reported she was not trying to harm Resident #20, that she posted it as a joke. Attempted interview with Resident #20 on 06/29/20 at 2:10 P.M. revealed the resident did not respond to the surveyor's questions. Review of the police report dated 06/29/20 revealed the police department was contacted by the Administrator in reference to an employee posting on social media of her combing a resident's hair and the resident telling her to stop. Police Officer #100 viewed the video and reported there were no signs of abuse. Review of STNA #01's personnel file revealed STNA #01 was hired on 10/22/19. STNA #01 had a Bureau of Criminal Investigation (BCI) check completed on 06/18/19 and the STNA registry was checked on 06/03/19 indicating STNA #01 was in good standing. Further review of STNA #01's personnel file revealed a disciplinary action form dated 06/24/20 indicating STNA #01 was suspended and terminated. The form indicated on 06/24/20, STNA #01 posted a live video of herself on social media providing care to a resident who had a [DIAGNOSES REDACTED].#01 brushing the resident's hair. The resident was waving her arms and grabbing her own hair telling STNA #01 to stop and calling STNA #01 names. STNA #01 responded to the resident and did not stop combing the resident's hair during the duration of the video. The video lasted 40 seconds. The termination was completed by telephone. STNA #01 was immediately suspended. Review of the facility's undated Abuse, Neglect and Exploitation policy revealed abuse to include the deprivation of an individual of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. The policy also stated that abuse includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enabled through the use of technology. The policy also reported the facility will develop and implement written policies and procedures that prohibit and minimize the risk of abuse, neglect and exploitation of residents. Review of the facility's undated Social Media policy revealed employees may not post on any social networking sites or accounts any photographs of other employees, residents, vendors or suppliers. The policy also stated employees may not use company time or any company owned equipment including but not limited to computers, software, Internet and cell phones or other electronic devices for social media. This deficiency substantiates Complaint Number OH 644.