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 _____	04/20/2020

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.

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F 0583 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of a medical record, personnel files, a facility self-reported incident (SRI), the facility Resident Imaging policy and local law enforcement interviews, the facility failed to ensure staff did not violate one resident's (Resident #71) right to privacy and confidentiality. This resulted in Immediate Jeopardy and psychosocial harm for Resident #71 when Certified Nursing Assistant (CNA) #111 pulled the resident's pants down to his ankles, exposing his genital area while State tested Nursing Assistant (STNA) #120 video recorded the incident without the resident's consent. This video was posted on a social media website, resulting in outcomes which one would expect a reasonable person in a similar situation to sustain humiliation and feelings of degradation. This affected one of three residents reviewed for privacy and confidentiality. On 0[DATE]5/20 at 9:32 A.M., the Administrator and the Director of Nursing (DON) were notified that Immediate Jeopardy began on 04/07/20 at approximately 7:00 P.M. when CNA #111 violated Resident #71's privacy and confidentiality and pulled his pants down around his ankles, in the hallway, exposing his genital area while STNA #120 recorded the actions of CNA #111. The video was later posted on social media by an individual who was not an employee at the facility and viewed an undetermined number of times. Review of the video revealed CNA #111 was observed with her mask down below her mouth and could be seen smiling and laughing after she pulled down Resident #71's pants. Resident #71 was observed agitated and upset during the incident. STNA #120 could be heard laughing during the incident. The Immediate Jeopardy was removed on 04/09/20 when the facility implemented the following corrective actions: On 04/09/20 at approximately 5:30 A.M., the DON received notification from Licensed Practical Nurse (LPN) #118 of a video involving a resident being posted on social media. The DON initiated an internal investigation involving the video and notified the Administrator of the posting on social media. The DON and Unit Manager LPN #117 attempted to contact CNA #111 and STNA #120 to obtain statements, however, they were unable to reach employees at this time. LPN #118 identified STNA #120 by voice recognition. On 04/09/20 at 5:45 A.M., the Regional Director of Operations educated the Administrator on the facility Abuse, Neglect, Exploitation, Misappropriation policy and facility policy for Resident Images. On 04/09/20 at 6:10 A.M. the Administrator notified local law enforcement of the incident and a report was filed. On 04/09/20 at 6:00 A.M. a head to toe assessment was completed on Resident #71 by LPN #117 with no abnormal findings. The DON and LPN #117 initiated like resident assessments with no abnormal findings. On 04/09/20 at 6:20 A.M. the Medical Director and Resident #71's attending physician were notified of the incident. A message was left for Resident #71's guardian to return a phone call to the facility. On 04/09/20 at 7:00 A.M. Unit Managers LPN #117, and Registered Nurse (RN) #106, Activity Director (AD) #133, Social Service Director (SSD) #126, and the Administrator began interviews for all residents regarding abuse, neglect or misappropriation and inquired if any resident had knowledge of an employee taking videos while providing care. Interviews were completed on 04/09/20 (no time identified). No negative responses were obtained. On 04/09/20 at 7:15 A.M. the Administrator submitted notification in the form of a SRI to the State Agency. On 04/09/20 at 7:30 A.M. the facility team, consisting of the Administrator, DON, LPN #117, RN #106, SSD #126, Human Resources staff (HR) #129 and AD #133 initiated the collection of statements from staff members regarding the incident on 04/07/20. On 04/09/20 at 7:45 A.M. the Interdisciplinary Team (IDT) consisting of the Administrator, DON, Unit Managers LPN #117 and RN#106, SSD #126, HR #129 and AD #133 met to review the SRI and develop the plan to investigate. On 04/09/20 at 9:00 A.M. HR #129 completed an audit of all employee files, background information and licensure status with no concerns identified. On 04/09/20 at 9:00 A.M., SSD #126 completed a psychosocial evaluation of Resident #71 which indicated no negative effects from the incident. On 04/09/20 at 9:15 A.M., the Administrator educated department managers including the DON, AD #133, Unit Managers LPN #117 and RN #106, SSD #126, HR #129 on the facility Abuse, Neglect, Exploitation, Misappropriation policy and facility policy for Resident Images. On 04/09/20 from approximately 9:20 A.M. through 8:00 P.M., the DON, AD #133, Unit Managers LPN #117 and RN #106, SSD #126, HR #129 educated 10 RNs, 16 LPNs, 42 CNAs/STNAs/Hospitality Aides, 16 Office Staff, 15 Therapy Staff, 10 Housekeeping Staff and 12 Dietary staff on facility Abuse, Neglect, Exploitation, Misappropriation policy and facility policy for Resident Images. All staff were in serviced except for CNA #111 and STNA #120 who were suspended. Inservice education occurred at the facility and per telephone for staff who were not scheduled to work on 04/09/20. On 04/09/20 at approximately 9:30 A.M., the Administrator completed notification to the State Agency Nurse Aide Registry of the incident with Resident #71 involving STNA #120 and CNA #111. On 04/09/20 at approximately 10:00 A.M. HR #129 and the DON notified CNA #111 and STNA #120 of suspension effective immediately pending investigation. On 04/09/20 at 11:05 A.M. SSD #126 spoke with Resident #71's guardian and informed him of the incident. On 04/09/20 at 11:30 A.M. an Ad-Hoc QAPI meeting with the Administrator, DON, RN #106, Medical Director, HR #129, SSD #126 and MDS RN #132 and #135, and RN #136 was held to review the incident regarding CNA #111 pulling Resident #71's pants down and STNA #120 recording the incident and the investigation process. On 0[DATE]3/20, STNA #120 and CNA #111 were terminated from employment at the facility for taking a video of a resident and posting it on social media and sharing it with other individuals. Neither employee had been in the building after 04/09/20. Termination notification was mailed via certified mail. On 0[DATE]3/20 between 1:23 P.M. to 2:30 P.M. and on 0[DATE]4/20 interview between 11:52 A.M. to 1:01 P.M. with Registered Nurse (RN) #106, LPN #117, #119, STNA #109, #110 #124, and SSD #126 reported they had been in-serviced on 04/09/20 regarding abuse prevention, resident privacy, and use of social media. 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 continued compliance. Findings Include: Record review revealed Resident #71 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #71 was discharged from the facility to the local emergency room for evaluation on [DATE] for becoming physically aggressive with another resident. Resident #71 was then transferred for an inpatient psychiatric hospital stay and on [DATE] was readmitted to the facility. Review of the Medicare five-day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #71 had a Brief Interview for Mental Status score of 2, indicating severe cognitive impairment and the resident was able to make himself understood. Resident #71 required extensive assistance with activities of daily living including toileting, dressing and personal hygiene. No behaviors were identified. A review of Resident #71's medical record revealed on 04/09/20 at 8:22 A.M. a weekly skin assessment was completed by LPN #117 which indicated no bruises, scratches or skin alterations were noted. A progress note by the DON on 04/09/20 at 8:30 A.M. indicated she was notified that an STNA had recorded a video of Resident #71 and the video had been posted on social media. Resident #71 was questioned regarding the incident and had no recollection voiced of any incidents of any kind. An investigation was initiated, SRI started, and local law enforcement was notified by the Administrator. The physician was notified, and the DON attempted to notify the guardian. Review of SSD #126's progress note on 04/09/20 at 9:27 A.M. indicated she met with Resident #71 and there were no signs or symptoms of distress noted. On 04/09/20 at 11:05 A.M., SSD #126 indicated she spoke with the resident's guardian and details of the incident were explained. Review of an undated social media video provided by the local police department revealed Resident #71 standing in a hallway when CNA #111 approached the resident and pulled

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

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F 0583 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1) his pants down to his ankles, exposing his genital area. STNA #120 was viewed video recording the incident. Resident #71 was observed stating I said not to (expletive) do these things now. Now who was it, you? The staff members were viewed laughing at the resident. Review of facility SRI # 1 dated 04/09/20 at 7:43 A.M. revealed around 6:00 A.M. on 04/09/20 the Administrator was notified of a video that was placed on social media regarding Resident #71 and CNA #111. The video appeared to have CNA #111 pulling Resident #71's pants down and STNA #120 recording the incident. The SRI indicated CNA #111 and STNA #120 were immediately placed on leave during pending investigation of the matter. Review of STNA #120's telephone statement dated 04/09/20 provided to the facility stated she was at the facility on 04/07/20, however, was not around when the video was taken. Review of a telephone statement dated 04/09/20 by CNA #111 indicated she played around with Resident #71 like that all the time. I was not expecting for his pants to fall because they were big on him. After the video was taken, I pulled his pants up, gave him a hug and said I was sorry. CNA #111 stated she was not sure who recorded the incident and was not sure how it was given to the individual who placed it on social media. Review of a statement from LPN #122 dated 0[DATE]3/20 indicated she was present when the incident between CNA #111 and Resident #71 occurred. LPN #122 stated she had her phone out to take a picture of STNA #113 when she walked through the door, however, she noted CNA #111 was pulling down Resident #71's pants so she immediately erased the video from her phone. LPN #122 indicated STNA #120 was observed with her phone out and pointed towards Resident #71. LPN #122 stated was not aware STNA #120 was recording when CNA #111 was pulling Resident #71's pants down until 04/09/20 when she saw the video on social media. LPN #122 stated she did not report the incident when it originally happened because she was intimidated by coworkers. An attempt to contact STNA #120 via telephone was made on 0[DATE]3/20 at 2:32 P.M. and 4:20 P.M. The phone call went straight to voice mail and indicated voice mail had not been set up. An attempt to contact CNA #111 was made on 0[DATE]3/20 at 2:34 P.M., however, a message was received the phone number had been discontinued. During a telephone interview with the Administrator on 0[DATE]4/20 at 10:31 A.M. he stated he was first made aware of the situation when the DON called him on 04/09/20 after 6:00 A.M. The Administrator reported the DON informed him of a video on social media and the DON forwarded the video to him. The Administrator reported he immediately notified the regional consultant for the facility and local law enforcement. He initiated a SRI when he arrived at the facility. The Administrator reported he instructed the DON to immediately contact the employees, obtain a telephone statement of what occurred and inform STNA #120 and CNA #111 of immediate suspension pending investigation. The Administrator reported no cameras were available on the secured unit to review the incident. The Administrator stated STNA #120 was not scheduled to work on 04/07/20, however, she came to the building and brought STNA #113 birthday gifts. A telephone interview on 0[DATE]4/20 at 11:00 AM with the DON revealed she was notified by LPN #118 on 04/09/20 around 6:00 A.M. of a video posted on social media regarding Resident #71 and CNA #111. The DON stated LPN #118 had received an anonymous call earlier that morning informing her of the video. The DON stated she immediately notified the Administrator and started the investigation. During a telephone interview with Unit Manager, LPN #117, on 0[DATE]4/20 at 12:20 P.M. revealed he had been notified by the DON on 04/09/20 of a video on social media with CNA #111 and Resident #71. LPN #117 reported he immediately came to work and completed the assessment on Resident #71. LPN #117 stated the resident was confused, however, had no increased behaviors and was cooperative. A telephone interview on 0[DATE]4/20 at 1:04 P.M. with LPN #118 revealed she had received an anonymous phone call at work on 04/09/20, somewhere around 6:00 A.M. informing her of a video posting on social media regarding a resident at the facility and CNA #111 and STNA #120. She stated she asked the caller where the video was found, and she gave the name of the individual who had posted the video. LPN #118 stated she immediately found the video and alerted the DON of the phone call and findings. A telephone interview with LPN#122 on 0[DATE]6/20 at 4:00 P.M. revealed she was present at the facility when CNA #111 pulled Resident #71's pants down, exposing his genital area. LPN #122 stated Resident #71 became upset when this happened. LPN #122 stated she did not report this incident. LPN #122 stated she was not aware of a video until 04/09/20 when she viewed the social media video. LPN #122 reported she was not aware of anyone 'taking' a video, however, STNA #120 was holding a phone out, pointed towards Resident #71 when the incident occurred. A review of Detective #130's investigative report dated 04/09/20 indicated the police department contacted STNA #120 who was then taken to the police department for an interview. During the interview, STNA #120 stated she was not aware of the video until 5:30 A.M. on 04/09/20 when CNA #111 informed her Citizen #146 had posted a video of her (CNA #111) pulling Resident #71's pants down at work. STNA #120 told Detective #130 she was not working when the incident occurred and was not present at the facility. STNA #120 told Detective #130 that Resident #71 had poor vision and explained staff would sometimes 'bark' and Resident #71 would call for the dog, asking where the dog was. STNA #120 again told the detective she had nothing to do with the video and was not present when the video was taken. STNA #120 informed Detective #130 it appeared the video was taken when Resident #71 was in the hallway. STNA #120 stated the video had been in CNA #111 photo gallery and Citizen #146 hacked her phone and uploaded the video. Review of Detective #130's investigative report revealed during an interview with CNA #111 on 04/09/20 she stated she was working on 04/07/20 on the secured unit and informed Resident #71 he needed to be changed and went to 'tug' on his pants when they just dropped. CNA #111 stated she did pull his pants back up. CNA #111 stated Citizen #146 got on her 'Snap Chat' and then posted the video on social media. CNA #111 stated she did not know who took the video. CNA #111 confirmed STNA #120 was present in the facility when the incident occurred, however, STNA #120 was not working. Telephone interview on 0[DATE]4/20 at 1:51 P.M. with Detective #130 revealed the department had received a call from a citizen the morning of 04/09/20 and later the Administrator called the department to inform them of a video on social media which included Resident #71 and staff members. Detective #130 stated he had interviewed CNA #111 and STNA #120 and was continuing to investigate the incident. Review of CNA #111's personnel file revealed she was hired on 09/05/19 as a hospitality aide and completed a Nurse Aide Training and Competency Evaluation Program on 02/20/20 but had not taken her state test. CNA #111 signed acknowledgement of the facility Abuse, Neglect and Exploitation policy on 09/05/19. The personnel file contained an Employee Corrective Action Form dated 04/09/20 which indicated CNA #111 was suspended pending investigation related to an incident with a resident on 04/07/20. CNA #111 was notified of her suspension by telephone. No previous disciplinary actions were noted for CNA #111. Review of STNA #120's personnel file revealed a hire date of 09/05/19 and had a current STNA certification through 12/02/21. STNA #120 had a most recent signed acknowledgement of the facility Abuse, Neglect and Exploitation policy on 01/06/20. The personnel file contained an Employee Corrective Action Form dated 04/09/20 which indicated STNA #120 was suspended during investigation of an incident with a resident on 04/07/20. Review of the facility policy Resident Images, dated 08/12/16 revealed the facility prohibits employees from taking photos in any fashion including posting on social media sites or videos that demean or humiliate a resident. This deficiency substantiates Complaint Number OH 783, OH 656, and OH 27.
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 files, a facility self-reported incident (SRI), facility video tape, facility Resident Images policy, facility Abuse, Neglect and Exploitation policy and interviews with staff and local law enforcement, the facility failed to ensure one cognitively impaired resident (Resident #71) was free from mental and emotional abuse by facility staff. This resulted in Immediate Jeopardy and psychosocial harm for one resident (Resident #71) when Certified Nursing Assistant (CNA) #111 pulled Resident #71's pants down to his ankles, exposing his genital area while State tested Nursing Assistant (STNA) #120 video recorded the incident without consent. This video was then posted on a social media website. Applying the reasonable person concept to the incident would result in the person feeling humiliated, demeaned and exploited. This affected one of three residents reviewed for abuse. On 0[DATE]5/20 at 9:32 A.M., the Administrator and the Director of Nursing (DON) were notified that Immediate Jeopardy began on 04/07/20 at approximately 7:00 P.M. when CNA #111 pulled Resident #71's pants down around his ankles exposing his genital area while STNA #120 recorded the incident. The video was later posted on social media and viewed an undetermined number of times. Review of the video revealed CNA #111 was observed with her mask down below her mouth and could be seen smiling and laughing after she pulled down Resident #71's pants in the hallway. Resident #71 was observed to be agitated and upset during the incident and was cursing at the staff. STNA #120 could be heard laughing as Resident #71's pants were pulled down and he became upset. The Immediate Jeopardy was removed on 04/09/20 when the facility implemented the following corrective actions: On 04/09/20 at approximately 5:30 A.M., the DON received notification from Licensed Practical Nurse (LPN) #118 of a video involving a resident being posted on social media. The DON initiated an internal investigation

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) involving the video and notified the Administrator of the posting on social media. The DON and Unit Manager, LPN #117, attempted to contact CNA #111 and STNA #120 to obtain statements, however, they were unable to reach employees at that time. LPN #118 identified STNA #120 by voice recognition. On 04/09/20 at 5:45 A.M., the Regional Director of Operations educated the Administrator on the facility Abuse, Neglect, Exploitation, Misappropriation policy and facility policy for Resident Images. On 04/09/20 at 6:10 A.M. the Administrator notified the [LOC] Police Department of the incident and a report was filed. On 04/09/20 at 6:00 A.M. a head to toe assessment was completed on Resident #71 by LPN #117. There were no abnormal findings from Resident #71's assessment. The DON and LPN #117 initiated like resident assessments with no abnormal findings. On 04/09/20 at 6:20 A.M. the Medical Director and Resident #71's attending physician were notified of the incident. A message was left for Resident #71's guardian to return a phone call to the facility. On 04/09/20 at 7:00 A.M. Unit Manager, LPN #117, Registered Nurse (RN) #106, Activity Director (AD) #133, Social Service Director (SSD) #126, and the Administrator began interviews for all residents regarding abuse, neglect or misappropriation and inquired if any resident had knowledge of an employee taking videos while providing care. Interviews were completed on 04/09/20 (no time identified). No negative responses were obtained. On 04/09/20 at 7:15 A.M. the Administrator submitted notification in the form of an SRI to the State Agency. On 04/09/20 at 7:30 A.M. the facility team consisting of the Administrator, DON, LPN #117, RN #106, SSD #126, Human Resources staff (HR) #129 and AD #133 initiated the collection of statements from staff members regarding the incident on 04/07/20. On 04/09/20 at 7:45 A.M. the Interdisciplinary Team (IDT) consisting of the Administrator, DON, Unit Managers LPN #117 and RN#106, SSD #126, HR #129 and AD #133 met to review the SRI and develop the plan to investigate. On 04/09/20 at 9:00 A.M. HR #129 completed an audit of all employee files, background information and licensure status with no concerns identified. On 04/09/20 at 9:00 A.M., SSD #126 completed a psychosocial evaluation of Resident #71 which showed no negative effects from the incident. On 04/09/20 at 9:15 A.M., the Administrator educated department managers including the DON, AD #133, Unit Managers LPN #117 and RN #106, SSD #126, HR #129 on the facility Abuse, Neglect, Exploitation, Misappropriation policy and facility policy for Resident Images. On 04/09/20 from approximately 9:20 A.M. through 8:00 P.M., the DON, AD #133, Unit Managers LPN #117 and RN #106, SSD #126, HR #129 educated 10 RNs, 16 LPNs, 42 CNAs/STNAs/Hospitality Aides, 16 Office Staff, 15 Therapy Staff, 10 Housekeeping Staff and 12 Dietary staff on facility Abuse, Neglect, Exploitation, Misappropriation policy and facility policy for Resident Images. All staff were in serviced except for CNA #111 and STNA #120 who were suspended. Inservice education occurred at the facility and per telephone for staff who were not scheduled to work on 04/09/20. On 04/09/20 at approximately 9:30 A.M., the Administrator completed notification to the State Agency Nurse Aide Registry of the incident with Resident #71 involving STNA #120 and CNA #111. On 04/09/20 at approximately 10:00 A.M. HR #129 and the DON notified CNA #111 and STNA #120 of suspension effective immediately pending investigation. On 04/09/20 at 11:05 A.M. SSD #126 spoke with Resident #71's guardian and informed him of the incident. On 04/09/20 at 11:30 A.M. an Ad-Hoc QAPI meeting with the Administrator, DON, RN #106, Medical Director, HR #129, SSD #126 and Minimum Data Set (MDS) 3.0 RNs #132 and #135, and RN #136 was held to review the incident regarding CNA #111 pulling Resident #71's pants down and STNA #120 recording the incident and investigation process. On 0[DATE]3/20, STNA #120 and CNA #111 were terminated from employment at the facility for taking a video of a resident and posting it on social media and sharing it with other individuals. Neither employee had been in the building after 04/09/20. Termination notification was mailed via certified mail. On 0[DATE]3/20 between 1:23 P.M. to 2:30 P.M. and on 0[DATE]4/20 interview between 11:52 A.M. to 1:01 P.M. with Registered Nurse (RN) #106, LPN #117, #119, STNA #109, #110 #124, and SSD #126 reported they had been in-serviced on 04/09/20 regarding abuse prevention, resident privacy, and use of social media. 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 continued compliance. Findings Include: Record review revealed Resident #71 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #71 was discharged from the facility to the local emergency room for evaluation on [DATE] for becoming physically aggressive with another resident. Resident #71 was then transferred for an inpatient psychiatric hospital stay and on [DATE] was readmitted to the facility. Review of the Medicare five-day MDS assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status score of 2, indicating severe cognitive impairment and the resident was able to make himself understood. Resident #71 required extensive assistance with activities of daily living including toileting, dressing and personal hygiene. No behaviors were identified. A review of Resident #71's medical record revealed on 04/09/20 at 8:22 A.M. a weekly skin assessment was completed by LPN #117 which indicated no bruises, scratches or skin alterations were noted. A progress note by the DON on 04/09/20 at 8:30 A.M. indicated she was notified that an STNA had previously recorded a video of Resident #71 and the video had been posted on social media. Resident #71 was questioned regarding the incident and had no recollection of any incidents of any kind. An investigation was initiated, SRI started, and local law enforcement was notified by the Administrator. The physician was notified, and the DON attempted to notify the guardian. Review of SSD #126's progress note on 04/09/20 at 9:27 A.M. indicated she met with Resident #71 and there were no signs or symptoms of distress noted. On 04/09/20 at 11:05 A.M., SSD #126 indicated she spoke with the resident's guardian and details of the incident were explained. Review of a social media video (video was not dated) provided by the local police department revealed Resident #71 standing in a hallway when CNA #111 approached the resident and pulled his pants down to his ankles, exposing his private area while STNA #120 video recorded the incident. Resident #71 was observed to turn to STNA #120 and state I said not to (expletive) do these things now. Now who was it, you? Review of the facility SRI # 1 dated 04/09/20 at 7:43 A.M. revealed around 6:00 A.M. on 04/09/20 the Administrator was notified of a video that was placed on social media regarding Resident #71 and CNA #111. The video appeared to have CNA #111 pulling Resident #71's pants down and STNA #120 recording the incident. The SRI indicated CNA #111 and STNA #120 were immediately placed on leave pending investigation of the matter. Review of STNA #120's telephone interview statement dated 04/09/20 provided to the facility indicated she was at the facility on 04/07/20, however, was not around when the video was taken. Review of a telephone interview statement dated 04/09/20 by CNA #111 indicated she played around with Resident #71 like that all the time. I was not expecting for his pants to fall because they were big on him. After the video was taken, I pulled his pants up, gave him a hug and said I was sorry. CNA #111 stated she was not sure who recorded the incident and was not sure how it was given to the individual who placed it on social media. Review of a statement from LPN #122 dated 0[DATE]3/20 indicated she was present when the incident between CNA #111 and Resident #71 occurred. LPN #122 stated she had her phone out to take a picture of STNA #113 when she walked through the door, however, noted CNA #111 was pulling down Resident #71's pants so she immediately erased the video from her phone. LPN #122 indicated STNA #120 was observed having her phone out and pointed towards Resident #71. LPN #122 stated was not aware STNA #120 was recording when CNA #111 was pulling Resident #71's pants down until 04/09/20 when she saw the video on social media. LPN #122 stated she did not report the incident when it originally happened because she was intimidated by coworkers. An attempt to contact STNA #120 via telephone was made on 0[DATE]3/20 at 2:32 P.M. and 4:20 P.M. The phone call went straight to voice mail and indicated voice mail had not been set up. An attempt to contact CNA #111 was made on 0[DATE]3/20 at 2:34 P.M., however, a message was received the phone number had been discontinued. During a telephone interview with the Administrator on 0[DATE]4/20 at 10:31 A.M. he stated he was first made aware of the situation when the DON called him on 04/09/20 after 6:00 A.M. The Administrator reported the DON informed him of a video on social media and the DON forwarded the video to him. The Administrator reported he immediately notified the regional consultant for the facility, the police department and initiated an SRI when he arrived at the facility. The Administrator reported he instructed the DON to immediately contact the employees, obtain a telephone statement of what occurred and inform STNA #120 and CNA #111 of immediate suspension pending investigation. The Administrator reported no cameras were available on the secured unit to review any footage. The Administrator stated STNA #120 was not scheduled to work on 04/07/20, however, she came to the building and brought STNA #113 birthday gifts, entered through the designated employee entrance, recorded her temperature and completed the facility COVID 19 health questionnaire. The Administrator revealed LPN #122's statement was obtained on 0[DATE]3/20 and when she indicated she was aware of the incident, however, did not immediately report due to intimidation by peers, she was immediately placed on suspension pending investigation. A telephone interview on 0[DATE]4/20 at 11:00 AM with the DON revealed she was notified by LPN #118 on 04/09/20 around 6:00 A.M. of a video posted on social media regarding Resident #71 and CNA #111. The DON stated LPN #118 had received an anonymous call earlier that morning informing her of the video. The DON stated she immediately notified the Administrator and started the investigation. A telephone interview with Unit Manager, LPN #117 on 0[DATE]4/20 at 12:20 P.M. revealed he had been notified by the DON on 04/09/20 of a video on social media with CNA #111 and Resident #71. LPN #117 reported he immediately came to work and completed the assessment on Resident #71. LPN #117 stated the resident was confused, however,

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 _____	**04/20/2020**

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) had no increased behaviors and was cooperative. A telephone interview on 0[DATE]4/20 at 1:04 P.M. with LPN #118 revealed she had received an anonymous phone call at work on 04/09/20, somewhere around 6:00 A.M. of a video posted regarding a resident at the facility and CNA #111 and STNA #120. She stated she asked the caller where the video was found, and she gave the name of the individual who had posted the video. LPN #118 stated she immediately found the video and alerted the DON of the phone call and findings. A telephone interview with LPN#122 on 0[DATE]6/20 at 4:00 P.M. revealed she was present at the facility when CNA #111 pulled Resident #71's pants down, exposing his private areas. LPN #122 stated Resident #71 became upset when this happened. LPN #122 stated she did not report this incident. LPN #122 stated she was not aware of a video until 04/09/20 when she viewed the social media video. LPN #122 reported she was not aware of anyone 'taking' a video, however, STNA #120 was holding a phone out, pointed towards Resident #71 when the incident occurred. A review of Detective #130's investigative report dated 04/09/20 indicated the police department contacted STNA #120 who was then taken to the police department for an interview. During the interview, STNA #120 stated she was not aware of the video until 5:30 A.M. on 04/09/20 when CNA #111 informed her Citizen #146 had posted a video of her (CNA #111) pulling Resident #71's pants down at work. STNA #120 told Detective #130 she was not working when the incident occurred and was not present at the facility. STNA #120 told Detective #130 that Resident #71 had poor vision and explained staff would sometimes 'bark' and Resident #71 would call for the dog, asking where the dog was. STNA #120 again stated she had nothing to do with the video and was not present when the video was taken. STNA #120 informed Detective #130 it appeared the video was taken when Resident #71 was in the hallway. STNA #120 stated the video had been in CNA #111's photo gallery and Citizen #146 hacked her phone and uploaded the video. Review of Detective #130's investigative report revealed during an interview with CNA #111 on 04/09/20, she stated she was working on 04/07/20 on the secured unit and informed Resident #71 he needed to be changed and went to 'tug' on his pants when they just dropped. CNA #111 stated she did pull his pants back up. CNA #111 stated Citizen #146 got on her 'Snap Chat' and then posted the video on social media. CNA #111 stated she did not know who took the video. CNA #111 confirmed STNA #120 was present in the facility when the incident occurred, however, STNA #120 was not working. Interview on 0[DATE]4/20 at 1:51 P.M. via telephone with Detective #130 of the police department revealed the department had received a call from a citizen the morning of 04/09/20 and later the Administrator called the department to inform them of a video on social media which included Resident #71 and staff members. Detective #130 stated he had interviewed CNA #111 and STNA #120 and was continuing to investigate the incident. Review of CNA #111's personnel file revealed she was hired on 09/05/19 as a hospitality aide and completed a Nurse Aide Training and Competency Evaluation Program on 02/20/20 but had not taken her state test. CNA #111 signed acknowledgement of the facility Abuse, Neglect and Exploitation policy on 09/05/19. The personnel file contained an Employee Corrective Action Form dated 04/09/20 which indicated CNA #111 was suspended pending investigation related to an incident with a resident on 04/07/20. CNA #111 was notified of her suspension by telephone. No previous discipline actions were noted for CNA #111. Review of STNA #120's personnel file revealed a hire date of 09/05/19 and had a current STNA certification through 12/02/21. STNA #120 had a most recent signed acknowledgement of the facility Abuse, Neglect and Exploitation policy on 01/06/20. The personnel file contained an Employee Corrective Action Form dated 04/09/20 which indicated STNA #120 was suspended during investigation of an incident with a resident on 04/07/20. Review of the facility policy Abuse, Neglect, and Exploitation, dated 01/19/17, revealed the facility would provide resident centered care to meet the psychosocial, physical needs of the resident. Abuse was defined as the willful infliction of mental anguish and included the deprivation of a caretaker to attain or maintain psychosocial well-being. Mental abuse was defined as including humiliation. Review of the facility policy Resident Images, dated 08/12/16 revealed the facility prohibits employees from taking photos in any fashion including posting on social media sites or videos that demean or humiliate a resident. This deficiency substantiates Complaint Number OH 783, OH 656, and OH 627.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, staff interview, self- reported incident (SRI) review, and review of facility self reported incident (SRI) and investigation, review of the facility Abuse policy, a facility staff person who witnessed resident abuse occur failed to immediately report it to the administrator. This affected one resident (Resident #71) of three residents reviewed for abuse with the potential to affect all 91 residents in the facility. Findings include: Review of the medical record for Resident #71 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Medicare five day Minimum Data Set (MDS) assessment (due to referral for skilled services, therapy), dated 04/02/20, revealed the resident had impaired cognition. The resident required extensive assistance with activities of daily living including toileting, dressing and personal hygiene. No behaviors were identified. Resident #71 was assessed as able to make self-understood and usually understands others. Review of the plan of care dated 04/09/20 revealed the plan of care indicated Resident #71 had a potential for psychological well-being problem and ineffective coping related to humiliation, victim of emotional abuse and violation of resident rights. Review of the video (not dated) provided to the surveyor by the facility revealed Certified Nursing Assistant (CNA) #111 was observed with her mask down below her mouth and could be seen smiling and laughing after she pulled down Resident #71's pants. Resident #71 was observed agitated and upset during the incident. State tested Nurse Aide (STNA) #120 could be heard laughing during the incident. Review of the Self Reported Incident (SRI) dated 04/09/20 and timed 7:04 A.M. indicated an incident occurred on 04/07/20 when an employee video taped a resident which was not in compliance with facility policy. The SRI indicated the Administrator was notified around 6:00 A.M. on 04/09/20 of a video that was published on social media regarding a resident and an employee. The video appeared to have a staff member pulling a resident's pants down and another staff member recording. Both staff members were immediately suspended pending investigation. A telephone statement dated 04/09/20 from CNA #111 in regards to the incident which occurred on 04/07/20 and signed by the Director of Nursing (DON) and Registered Nurse (RN) #106, indicated CNA #111 reported she 'played around' with Resident #71 like that all the time and CNA #111 was not expecting Resident #71's pants to fall down because they were too big. Review of a telephone statement dated 04/09/20 from STNA #120 revealed she denied taking the video of Resident #71 when CNA #111 pulled his pants down in the hallway. Review of a written interview statement from Licensed Practical Nurse (LPN) #122 dated 0[DATE]3/20 indicated she and LPN #115 went to the secured unit to see birthday gifts for STNA #124 which STNA #120 brought to the facility. LPN #122 indicated while waiting she observed CNA #111 pulling Resident #71's pants down. LPN #122 reported STNA #120 had a phone out and pointed toward Resident #71 and CNA #111. LPN #122 indicated she was not aware of the video until it was on Facebook. LPN #122 stated she did not report the incident immediately because she was intimidated by coworkers. Review of LPN #122's personnel file revealed she was immediately suspended after her statement was obtained on 0[DATE]3/20 pending further investigation regarding the incident. A phone interview on 0[DATE]4/20 at 11:00 A.M. with the DON revealed she was not aware of LPN #122 had observed the CNA #111 pulling down Resident #71's pants nor the event was not immediately reported. The DON stated they had continued to obtain statements for the investigation and LPN #122 was the last statement they had obtained. The DON stated no other staff member had reported any prior knowledge of the video before 04/09/20, and when she called STNA #120 she denied taking the video. A phone interview on 0[DATE]6/20 at 4:00 P.M. with LPN #122 revealed she was present on E Hall when CNA #111 pulled Resident #71's pants down. When asked if she reported this to anyone, LPN #122 stated she did not report the incident to her Unit Manager or DON due to felt intimidated by coworkers. Review of the facility policy Abuse, Neglect, and Exploitation, dated 01/19/17, revealed the policy indicated all violations should be reported immediately. This deficiency substantiates Complaint Number OH 783, OH 656, and OH 627.