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	345575	A. BUILDING ______ B. WING ______	C 11/06/2023

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted onsite 11/01/23 through 11/02/23. Additional information was obtained offsite on 11/06/23. Therefore, the exit date was 11/06/23. Event ID # 9ZEK11. The following intakes were investigated: NC00208187, NC00208870, and NC00209028. 1 of 3 complaint allegations resulted in deficiency. Past non-compliance was identified at: CFR 483.12 at tag F600 at scope and severity (G) Non-compliance for F600 began on 10/05/23 and was corrected on 10/7/23. The facility came back in compliance on 10/27/23 as a result of an onsite revisit conducted at the same time as this complaint investigation.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/15/2023

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 600	Continued From page 1 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, Psychiatric Social Worker, Nurse Practitioner, Medical Director, and Psychiatric Physician's Assistant interviews the facility failed to protect a resident's right to be free from mental abuse by a visitor when the visitor was found to have posted a video recording of a cognitively impaired resident that included a caption with a demeaning comment, and the visitor was heard on the video mocking and ridiculing the resident while the resident was lying in bed and exhibiting behaviors of yelling out. This occurred to 1 of 1 Resident (Resident #1) reviewed for visitor to resident abuse. The video was posted on two social media platforms. This action would have caused a reasonable person psychosocial harm such as feelings of shame, humiliation, agitation, and degradation. Findings included. Resident #1 was admitted to the facility on 07/31/20 with diagnoses including in part; vascular dementia with mood disturbance and cerebral vascular accident (CVA). A care plan dated 06/12/23 revealed Resident #1 had severely impaired cognition and received antianxiety medication due to agitation. The goal of care included Resident #1's cognitive deficits would not infringe on their rights or the rights of others. Interventions included to administer medications as ordered and to be patient with the resident.	F 600	Past noncompliance: no plan of correction required.	

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The Minimum Data Set (MDS) quarterly assessment dated 09/23/23 revealed Resident #1 was severely cognitively impaired and required extensive two-person assistance with activities of daily living (ADLs). He received antianxiety and antidepressant medications.

A progress note dated 10/06/23 at 1:06 PM documented by the Director of Nursing (DON) revealed; this morning the facility was notified that another residents family videoed Resident #1 in his room yelling out and posted it to social media. Immediate interventions included Resident #1 was monitored and had no adverse effects noted regarding the incident. No new skin impairments were noted. His vital signs were stable. He was responsive, pleasant, and cooperative. He had full range of motion to all extremities. Neurological checks were within normal limits. He had no complaints of pain. His skin tone was normal, warm, and dry. His respirations were unlabored. His heart rate was within normal limits. Resident #1's Responsible Party (RP) was notified of the occurrence. Resident #1 had no signs or symptoms of anxiety or depression. Resident #1 was unable to state that he had visitors. Resident was pleasant and smiling when speaking. The Nurse Practitioner (#1) was made aware, with no new orders given.

A Social Services note dated 10/06/23 at 2:33 PM documented by Social Worker #1 revealed; Today I went to visit with Resident #1 to ensure he had no concerns of distress following a reported incident. He was sleeping peacefully, while his (RP) was at his bedside.

An Interdisciplinary Team (IDT) meeting note dated 10/10/23 at 1:28 PM revealed Resident #1

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was being monitored for negative outcomes related to a recent incident involving individuals visiting the facility. No negative outcomes had been noted at this time, but we will continue to monitor. The attendees included the Administrator, DON, unit managers, AIT (Administrator in Training) , and Dietary Manager.

A progress note dated 10/10/23 at 5:00 PM documented by the Unit Manager revealed; during the weekly review, the team discussed Resident's #1's alleged abuse. This resident's mood and affect were pleasant and cooperative. He was involved in activities and participated daily. He was yelling less frequently and was easily redirected once his needs were met.

A progress note dated 10/12/23 documented by Nurse Practitioner #1 revealed Resident #1 was lying in bed, he was in no acute distress, and he was inattentive during the exam. His eyes opened spontaneously, and he was not willing to answer questions. He had baseline dementia though he was able to make his needs known. His mood was stable, and he was followed by Psychiatric Services. The plan of care included in part to continue antidepressant medications.

An encounter note dated 10/24/23 at 11:00 PM documented by Nurse Practitioner #1 revealed in part; staff reported Resident #1 was screaming and calling out last night with altered mental status, and disturbing other residents as they slept. In September he was getting as needed Ativan (antianxiety medication) however it was then changed to scheduled dosing twice a day. He also currently had an active UTI (urinary tract infection) which had affected his mentation. Generally, he is resting in bed with his eyes

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F 600	Continued From page 4 closed during the day. I discussed with staff the impact of his altered circadian rhythm and his sleep wake cycle as he was sleeping all day, he will then be awake and more active during the night. The plan of care included in part; Trazadone (hypnotic) 50 milligrams as needed for insomnia at bedtime and continue scheduled Ativan. An observation was conducted of Resident #1 on 11/01/23 at 1:00 PM. Resident #1 was observed lying in bed with his eyes closed. He was in no distress. During an interview on 11/01/23 at 1:45 PM the DON stated a staff member (#1) notified her on the morning of 10/06/23 that she saw a video posted on social media of Resident #1. She stated the video was made by another residents family member (Visitor #1) who posted it to social media on the evening of 10/05/23. She stated the video showed Resident #1 lying in bed yelling out and being taunted by Visitor #1. She stated a second person, Visitor #2, was also heard saying something about going down to say something to Resident #1 if he did not stop yelling. She stated Visitor #1 recorded from the doorway of Resident #1's room, as he was in the bed closest to the door. She stated Resident #1 was recorded fully clothed but yelling out. She stated Visitor #1 was heard on the video saying, "why are yelling, and "you're disturbing my babies". The Administrator, the Police, and Resident #1's RP were notified. She stated the Administrator called Visitor #1 on 10/06/23, and she stated she didn't see anything wrong with what she did and stated she would apologize to the resident. The Administrator informed her that she would not be allowed to have any contact with Resident #1. They	F 600		

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F 600	Continued From page 5 informed her that she or Visitor #2 could no longer visit without supervision from the facility Social Worker or the family members legal guardian Adult Protective Services (APS). She stated APS was made aware of this incident and agreed with this plan. She indicated staff members were also aware that if Visitor #1 or Visitor #2 were observed in the facility unsupervised they were to immediately notify a manger, the DON, or the Administrator. She stated the Police Officer informed them that it was not a criminal matter. She stated Visitor #1 or Visitor #2 had not been to the facility since the incident occurred. The DON stated Resident #1 had severe dementia and didn't know that this had occurred, and stated due to his severe cognitive impairment he would not be able to recall this incident. He had behaviors such as yelling out which escalated in the evenings. She stated these behaviors occurred prior to this incident and continued to occur, and he received Ativan scheduled twice a day for these behaviors. She stated she started an investigation on 10/06/23 which included resident assessments for safety, skin assessments, and staff interviews. In-service training was initiated on 10/06/23. She stated a sign was posted on the front entrance door stating no video recordings were allowed without permission. She stated audits of residents were being conducted according to their abuse protocol which included skin assessments for signs or symptoms of abuse. The audit included speaking with alert and oriented residents using a questionnaire asking if; any abuse had occurred including verbal, physical, or mental abuse, had they ever witnessed abuse, and what would they do if they did witness abuse. She stated the audits were ongoing 3 times a week over the next 4 weeks. She stated they informed Visitor #1 to	F 600		

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F 600	Continued From page 6 remove the post from social media and stated as far as she knew it had been removed. She stated she saved a recording of the social media post to have for the investigation. An observation was made of the social media post of Resident #1 by the surveyor along with the DON. The caption read; This "explicative" is so funny!! Then it showed Resident #1 lying in bed, yelling out. Resident #1 was fully clothed. Visitor #1 was heard laughing at Resident #1 and taunting him saying" you want to get up, you can get up", and "you're disturbing my babies", and she continued to laugh at him. Visitor #2 was not heard on the video recording. During an interview on 11/01/23 at 2:00 PM the Medical Director stated Resident #1 was a 90-year-old resident who was admitted 07/31/20 with vascular dementia and CVA and had severely impaired cognition. He stated his last evaluation was done on 09/20/23 before the incident. He stated the Nurse Practitioner (#1) had evaluated him since the incident on 10/05/23. He stated he was not aware of the incident, but he had not had any staff member report any change in his behaviors to him since that time. He stated Resident #1 had behaviors of yelling out prior to and since this incident and was followed by Psychiatric services. He stated having a video recorded and then posted to social media was an invasion of the residents privacy, and stated it was a demeaning act that was carried out by the visitor. He indicated a reasonable person would not want to be recorded and posted on social media. He indicated a reasonable person would be distraught and humiliated if this were to happen to them.	F 600		

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An interview was conducted on 11/01/23 at 3:00 PM with Staff member #1 who viewed the video on social media and reported it to the Administrator and DON. She stated she had worked at the facility for over 5 years and was familiar with Resident #1. She stated on the morning of 10/06/23 she was on social media and came across the video of Resident #1. She stated the video started out with Resident #1 yelling, and then Visitor #2 was heard saying something about he was going to go down and say something to Resident #1 if he didn't stop yelling. Resident #1 continued to yell and was saying he wanted to get up, and Visitor #1 told him he was scaring her babies who were with her visiting. She stated as Resident #1 continued to yell, Visitor #1 put the camera on his face and was laughing at him then it was posted on social media. She stated one of the social media platforms where the video was posted, automatically deleted the video after 24 hours but on the other social media platform the video would continue to be there unless it was removed by the person who posted it. She stated she thought the video had been removed by Visitor #1 after the Administrator called her. She stated she immediately reported it to the Administrator because the content was very inappropriate. She stated following the incident she had received training on abuse and on video recording in the facility, and to immediately report if this was witnessed.

During an interview on 11/01/23 at 4:00 PM Nurse Aide #1 stated she was Resident #1's assigned nurse aide on the evening of 10/05/23. She stated she did not witness Visitor #1 or Visitor #2 going to Resident #1's room and recording him on video. She indicated she was made aware of

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F 600	Continued From page 8 the social media posting the day the Administrator and DON were made aware. She stated she must have been passing dinner trays during that time, which included going onto another hallway to pass trays, and stated it must have occurred when she was on the other hallway. She stated she was aware that Visitor #1 was visiting her family member but never saw Visitor #1 or Visitor #2 until they were leaving the facility which was around dinner time. She stated if she had witnessed the incident, she would have immediately reported it to management. She stated Resident #1 was not oriented and had behaviors such as yelling out even though he would not need anything. She stated he had these behaviors before the incident and continued to have behaviors of yelling out. She stated she had received abuse training since the incident. A phone interview was conducted on 11/01/23 at 5:30 PM with the Psychiatric Social Worker who provided social services to Resident #1. She indicated she was not aware of the incident regarding Resident #1. She stated her initial visit with Resident #1 was on 08/09/23 and the most recent visit was on 10/22/23. She stated when she first met him on 08/09/23 he had a history of anxiety, depression, tearfulness, and insomnia. She stated on her last visit he was depressed, and she noted he had a hard time getting comfortable. She stated Resident #1 had severe cognitive impairment and he did not mention anything to her about being recorded or being unsafe in the facility. She stated she didn't think that Resident #1 would be aware of the incident happening or have any knowledge of social media and the repercussions of having a video posted. She stated due to his cognitive	F 600		

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impairment Resident #1 would not be able to express his feelings or give a discernable response regarding being exposed on social media. She indicated having a video of him lying in bed yelling out would be demeaning and a reasonable person would be humiliated, and it could cause a person to have psychosocial harm if that happened to them.

During an interview on 11/02/23 at 2:00 PM Nurse Practitioner #1 stated she was made aware of the incident regarding Resident #1. She stated Resident #1 had severe dementia and had behaviors of yelling out before and after the incident. She stated due to his age, and dementia, he would not be aware of the video and would not be aware of any implication of having the video posted on social media. She stated on her last evaluation on 10/30/23 Resident #1 was calm, and not in distress and appeared to be at baseline. She stated Resident #1 had sundowning at night but no change in behaviors that had been reported to her. She stated he received antianxiety medication which was scheduled for administration twice a day. She stated no reasonable person would want a video of them in a nursing facility posted on social media. She indicated this could cause a person to experience psychosocial harm.

During an interview on 11/02/23 at 2:30 PM Nurse #1 stated he was the assigned nurse to Resident #1 on 10/05/23, the evening the incident occurred. He stated around 5:30- 6:00 PM Visitor #1 along with a male friend (Visitor #2) came in to visit with Visitor #1's family member. He stated Resident #1 had dementia with behaviors and yelled out, but he would calm with interventions from staff. He stated the nurse aides had been

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down a couple of times to calm Resident #1 but that evening he continued to yell out. He stated he never saw Visitor #1 or Visitor #2 go down to Resident #1's room and didn't see them until they were leaving the facility around 7:00 PM. He stated if he had witnessed her videoing Resident #1, he would have stopped it and would have informed her that it was inappropriate. He stated soon after at 7:00 PM a nurse aid who Resident #1 responded very well to came in for her shift and Resident #1 did calm down when she went in with him. He stated he routinely provided care to Resident #1 and the behaviors of yelling out occurred prior to the incident and he continued to have these behaviors primarily in the evenings and during the night. He stated Resident #1 had increased agitation at times before and following the incident and received scheduled anti-anxiety medication twice a day. He stated he had never witnessed Visitor #1 or Visitor #2 being inappropriate or saying anything to other residents before this incident. He stated he had received abuse training and training on video recordings since the incident.

During an interview on 11/02/23 at 3:00 PM Nurse Aide #2 stated she was assigned to part of Resident #1's hall that evening but she was not his assigned nurse aide. She stated she was shocked at the video, and she was not aware that evening that a video had been made. She stated she and Nurse Aide #1 must have been passing trays on another hall during that time because she never saw Visitor #1 or Visitor #2 go down to Resident #1's room. She stated she saw the video after being told by staff the next day. She stated Visitor #1 didn't really visit often as far as she was aware but stated she could be loud at times when she did visit. She stated she had

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never witnessed Visitor #1 or Visitor #2 being inappropriate or saying anything to other residents. She stated she did receive abuse training since the incident.

During an interview on 11/02/23 at 3:30 PM with the Unit Manager she stated she had never been at the facility when Visitor #1or Visitor #2 were there. She stated she was not aware of any concerns regarding Visitor #1 or Visitor #2 prior to this incident. She stated Resident #1 had dementia, with longtime behaviors, and was followed by Psychiatric Services. She stated there had been no change in Resident #1's behaviors, and stated he yelled out before the incident and still continued to do so. She stated Visitor #1 or Visitor #2 had not returned to the facility since the incident, but future visits would be supervised. She stated staff education was provided by the DON regarding not videoing a resident, whether visitor or staff. She stated weekly audits were ongoing.

An interview was conducted on 11/02/23 at 6:00 PM with the Administrator along with the DON. The Administrator stated he was disturbed by the incident and immediately called Visitor #1 on 10/06/23 when he was made aware. He stated Visitor #1 didn't think it was wrong to record another resident in the facility. He stated he informed her that it was not appropriate and to remove the video from social media. He also informed Visitor #1 that future visits to the facility would be supervised. He stated a full investigation was completed and the police were notified. He stated a police officer came to the facility to investigate but stated it was a civil matter and not a criminal matter. He stated Resident #1's RP was notified along with APS

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F 600	Continued From page 12 and the State Agency. A phone interview was conducted on 11/06/23 at 10:45 AM with the Psychiatric Physician's Assistant. She stated she was the Psychiatric provider for Resident #1. She stated she was not aware of the incident regarding the video recording. She stated Resident #1 had severe dementia with behaviors and had no concept of reality and would not have any concept of this incident. She stated Resident #1 was actively delusional and yelling out which was a behavior prior to this incident and the behaviors continued to occur. She stated she evaluated him last on 10/17/23 and his mood was stable. She stated a reasonable person would experience psychosocial harm and would be extremely distraught and humiliated if this were to occur to them. Further observations were made during the investigation of Resident #1. He was observed each time lying in bed with his eyes closed. He was in no distress. He would arouse to his name but could not participate in meaningful conversation. Alert and oriented residents were interviewed during the investigation, and each stated they felt safe in the facility and had no concerns with visitors coming into the facility. Attempts were made to contact Resident #1's RP during the investigation. There was no response. The corrective action for the noncompliance dated 10/06/23 was as follows: On 10/06/23 at 9:00 AM the DON was notified by	F 600		

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	345575	A. BUILDING ______ B. WING ______	C 11/06/2023

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F 600	Continued From page 13 a staff member that they observed Resident #1 on social media being recorded by Visitor #1. The recording was made the night before (10/05/23) around dinner time of him in his room. He was recorded on video yelling out with Visitor #1 laughing at him. On 10/06/23 at 10:00 AM the DON and Administrator were notified that Visitor #1 posted the video on a 2nd social media platform. The facility was also notified that Visitor #2 stated he was going to go down to Resident #1's room if he did not stop yelling. On 10/06/23 at 10:30 AM the State Agency was notified. On 10/06/23 at 10:45 AM Resident #1's Responsible Party was notified. On 10/06/23 at 11:00 AM the Police were notified. On 10/06/23 at 12:00 PM staff who worked the evening of 10/05/23 were interviewed. Staff interviews revealed Resident #1 was heard yelling out and staff provided assistance to calm him. Each staff member interviewed stated they knew Visitor #1 was in the facility to visit her family member, but no staff observed her going in any other residents room. On 10/06/23 at 1:00 PM the Social Worker visited with Resident #1, he was pleasant and cooperative. He was unaware of the recording that occurred on 10/05/23 due to his advanced dementia. Resident #1 stated he felt safe. On 10/06/23 at 2:00 PM the Administrator spoke with Visitor #1 and requested the video to be	F 600		

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F 600	Continued From page 14 removed from social media sites. Visitor #1 was informed that recording a resident was not allowed and future visits would need to be supervised with the facility Social Worker or with the APS representative. Visitor #1 verbally agreed to this arrangement. On 10/06/23 at 3:30 PM the Administrator and DON met with Resident #1's RP. Signs were placed on entrance doors of the facility to remind visitors that residents could not be recorded on video without consent. On 10/06/23 alert and oriented residents were interviewed regarding abuse, skin assessments were conducted of cognitively impaired residents. Audits of residents were conducted according to the abuse protocol which included body audits/skin assessments for signs or symptoms of abuse. The audit included speaking with alert and oriented residents using a questionnaire asking if; any abuse had occurred including verbal, physical, or mental abuse, had they ever witnessed abuse, and what would they do if they witnessed abuse. No concerns were identified. On 10/06/23 in-service training was initiated for all staff. The training included in part; the facility would not tolerate abuse, neglect, mistreatment, exploitation of residents. Facility staff must immediately report all such allegations to the Administrator. Investigations would begin immediately. The facility would not tolerate exploitation of a resident which included abuse that was facilitated or caused by taking or using photographs or audio-visual recordings in any manner that would demean or humiliate a resident. Education was provided on what actions to take if this was observed by staff. All staff	F 600		

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F 600	Continued From page 15 would be required to complete training prior to their next shift. On 10/06/23 staff had been instructed if Visitor #1 or Visitor #2 were in the facility unsupervised, they should immediately notify a manager, the DON, or the Administrator. On 10/10/23 an Ad Hoc QAPI (Quality Assurance and Performance Improvement) meeting was held. A risk tool was initiated which included questions about abuse to alert, and oriented residents, and observations of cognitively impaired residents. Monitoring and body audits would be conducted x 12 weeks and reviewed monthly in QAPI meetings x 3 months. On 11/02/23 the DON stated all staff were aware of Visitor #1 and Visitor #2 requiring supervised visits moving forward. She stated staff had been instructed that if they saw Visitor #1 or Visitor #2 in the facility unsupervised, they should immediately notify a manager, the DON, or the Administrator. She indicated supervision would be with the Social Worker, DON, Administrator, or a manger if the Social Worker was not in the facility. She stated Visitor #1 was also informed supervised visits could be conducted with the APS representative as well, and arrangements would need to be made with APS. She stated after completing the investigation it was determined that audits would be conducted for only 4 weeks. She stated audit results would be forwarded to the QAPI committee monthly x 1 month. The QAPI committee will meet and review the results of audits and determine the need for continued monitoring. She stated the next QAPI meeting would be held November 2023.	F 600		

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F 600	Continued From page 16 Validation of the corrective action was completed on 11/02/23. This included staff interviews regarding the incident, and in-service training that was received to ensure understanding and knowledge of the training provided. Interviews were conducted with alert and oriented residents and observations were made of cognitively impaired residents. The audits were verified. There were no concerns identified. The next QAPI meeting was scheduled to be held November 2023 where audit results would be discussed. The facility's alleged compliance with the corrective action plan on 10/07/23 was validated.	F 600		