

**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

Amended 10/17/17 JKM

Citation Number: #6465					Date: March 3, 2017
Facility Name: Clarksville Skilled Nursing & Rehab Center		Survey Dates: February 15 – 16, 2017			
Facility Address/City/State/Zip 115 North Hilton St. Clarksville, IA 50619		JKM/KK			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date	

58.43(1)	<p>481—58.43(135C) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from mental, physical, sexual, and verbal abuse, exploitation, neglect, and physical injury. Each resident shall be free from chemical and physical restraints except as follows: when authorized in writing by a physician for a specified period of time; when necessary in an emergency to protect the resident from injury to the resident or to others, in which case restraints may be authorized by designated professional personnel who promptly report the action taken to the physician; and in the case of an intellectually disabled individual when ordered in writing by a physician and authorized by a designated qualified intellectual disabilities professional for use during behavior modification sessions. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II)</p> <p>481-58.43(1) Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. (II)</p>	I	\$2000 Held in Suspension	On Receipt
58.45(1)	<p>481—58.45(135C) Dignity preserved. The resident shall be treated with consideration, respect, and full recognition of dignity and individuality, including</p>			

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	<p>privacy in treatment and care for personal needs. (II)</p> <p>58.45(1) Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. (II)</p> <p>DESCRIPTION:</p> <p>Based on record review, staff interviews, and facility policy review, the facility failed to ensure each resident was provided kind and considerate care at all times and was free from mental abuse. The facility also failed to ensure each resident was treated with respect and full recognition of their dignity and individuality. A staff member posted a humiliating photograph of Resident #1 on a social media site called, "Snapchat." Record review revealed the resident displayed cognitive impairments and relied on extensive staff assist with his/her Activities of Daily Living (ADLs). Resident #1 could not advocate for him/her (self). Staff E admitted she posted the photo of the resident on Snapchat. A reasonable person would be embarrassed and feel degraded if his/her care provider humiliated him/her in this manner. A concern was identified for 1 of 4 residents reviewed</p>				
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	<p>(Resident #1). The facility identified a census of 36 residents.</p> <p>Findings include:</p> <p>Review of the clinical record revealed Resident #1 had diagnoses that included diabetes, heart disease, high blood pressure, osteoarthritis, and unspecified kidney failure.</p> <p>According to the Minimum Data Set (MDS) assessment tool dated 2/2/16, Resident #1 experienced both long and short term memory problems with severely impaired cognitive skills for daily decision making. The MDS documented Resident # 1 required extensive staff assist with bed mobility, transfers, personal hygiene; dining and toilet use, and was not able to ambulate (walk).</p> <p>The facility's individual plan of care dated 2/10/16 documented the resident required assistance with ADLs due to a diagnosis of dementia and a history of cerebral vascular accident (stroke). The care plan directed staff to:</p> <p>* Utilize the mechanical sit to stand lift with assist of two staff for all transfers.</p>				
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	<p>* Provide the resident perineal care and adult pull-up briefs after toilet use due to bowel and bladder incontinence.</p> <p>During an interview on 2/16/17 at 11:35 a.m., the facility administrator indicated at 2/6/17 at 8:01 p.m., a community member notified her that a facility employee sent a Snapchat of a staff member holding BM (bowel movement) in the palm of his/her gloved hand in the photo; a resident's buttocks were also visible. The administrator reported she immediately went to the nursing facility and initiated an investigation. The administrator stated the community member told her he/she saw the photo at approximately 7:55 p.m. that evening.</p> <p>Snapchat is a messaging application that allows a user to take photographs and video and add text and drawings. The photos or video that are sent are known as "Snaps." Once the person that receives the Snap opens it, the photo disappears in 10 seconds. The viewer has the ability to save the picture by taking a screen shot. If someone does take a screen shot, the sender is notified, and appears on the sender's Snapchat Log. Snapchat community guidelines directed their users to keep it legal and also directed users not to take Snaps of people without their knowledge or consent. The</p>				
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	<p>community guidelines urged their users not to take Snaps of people in places that would violate their privacy such as bathrooms. The guidelines did not address humiliation.</p> <p>During an interview on 2/15/17 at 2:00 p.m., Staff A reported she worked with and was familiar with Resident #1. Staff A also reported Resident #1 was almost totally dependent on staff for transfers from surface to surface, toilet use and dining, and was almost always incontinent of bowel and bladder. Staff A stated facility policy prohibited staff from carrying their cell phone on their person while on duty, although phones were permitted in the facility's break room. She added not all staff abided by the policy.</p> <p>Staff A reported on 2/6/17 she was getting off work (at a different job) when she received a Snapchat from Staff E, so she opened it. She stated it was a photo of a gloved hand that held a pile of BM. She described it as if a resident was in the process of defecating and staff "caught" the feces. Staff A stated she was unable to see the resident's (face) but did see bare buttocks from the lower back to mid-thigh area. Staff A stated she knew the photo was a resident and staff person and added it included a typed message: something to the effect</p>				
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	<p>of, "this is what I do at my job."</p> <p>According to the written facility investigation, the administrator spoke with Staff A on 2/6/17 at 8:38 a.m. Staff A reported she was not at the nursing home at the time of the incident, but did receive the Snapchat. Staff A stated she opened the photo and saw buttocks but did not know whose because she closed it quickly. When the Administrator asked why Staff A did not report the picture to facility management, Staff A said, "I didn't even think about it because I couldn't see who it was because I clicked out of it so fast."</p> <p>During an interview on 2/15/17 at 2:21 p.m., Staff B stated she worked with and was familiar with Resident #1. She reported the resident required 2 staff and an EZ Stand (lift) to assist with transfers. Staff B stated facility policy did not allow staff to carry their cell phones while on duty but they could be kept in the breakroom. Staff B reported taking pictures of residents or their bodies was a "no-no." Staff B stated on the evening of the incident she received a Snapchat notification, and when she opened it later observed a hand with BM on it. She also stated she did not recall seeing any other body parts and could not remember what the accompanying text had read. She added she didn't</p>				
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	<p>think it was a very professional thing to do and was shocked that a staff person would do such a thing. Staff B stated she thought at the time it was wrong and the incident should have been reported (to administration), but admitted she did not do so because Staff E was a friend.</p> <p>During an interview on 2/15/17 at 2:39 p.m., Staff C stated she was familiar with Resident #1 and he/she required 2 staff assist with an EZ Stand for transfers. She also stated it was facility policy for staff not to have cell phones on their person while at work, only in the breakroom. Staff C also indicated it was against facility policy for staff to take pictures of residents or any body part of a resident. She recalled seeing a staff member about a year ago that carried her phone on her, but that staff person no longer worked at the facility. Staff C stated on the day of the incident, she checked her cell phone between "6:00 and 7:30(ish) p.m." and noted she had received a message from Staff E: a picture of a hand with BM on it. Staff C stated she didn't notice any resident body parts included in the photo, but saw a text that mentioned something about what she (Staff E) did at her job. Staff C stated it did not cross her mind that it was wrong to take a photo and send it via Snapchat and she did not report the incident because it also did not cross her mind that it</p>				
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	<p>could be potential abuse.</p> <p>During an interview on 2/16/17 at 10:14 a.m., Staff D stated it was facility policy for staff to not have cell phones on their person during work time, and staff were not allowed to take photos of residents. Staff D stated on the day of the incident she (Staff D) and Staff E were assisting Resident #1 to bed following the evening meal. Staff D stated Resident #1 was positioned in the EZ stand (for a transfer) and they had completed perineal cares. Staff D stated a clean adult brief had been placed when Resident #1 again began to defecate. Staff D stated Staff E "caught" the bowel movement in her gloved hand so the clean brief would not be soiled. Staff D stated she next observed Staff E take a photo with her cell phone of what Staff D thought was Staff E's gloved hand holding the bowel movement, then put her phone away. Staff D stated she did not report the incident, nor was she aware at that time Staff E sent the picture to other individuals and the photo included a text message. Staff D confirmed the photo also included Resident #1's "private parts" and verified Resident #1 did not consent to being photographed.</p> <p>During an interview on 2/16/17 at 10:58 a.m., Staff E stated she was familiar with Resident #1 and noted</p>				
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	<p>he/she required "extensive care" and 2 staff assist for an EZ stand transfer. Staff E reported the facility had zero tolerance for staff to have cell phones on their person while working and staff could only have their cell phones in the break room. Staff E stated she thought the day shift followed the policy better than second shift staff. Staff E admitted she did have her cell phone on her person a few times per week. She recalled she also saw other staff with their cell phones as well, but they checked/used them during "down times" in the cubbies where the Kiosk was located. Staff E added it was even more unacceptable for staff to take pictures of residents.</p> <p>Staff E described the evening of the incident as a usual day. She stated she and Staff D were getting Resident #1 ready for bed at about 7:00 p.m. and perineal cares had been completed. As the staff began to put a new brief in place, Resident #1 started to defecate again. Staff E stated she did not want Resident #1 to soil a second brief so she "caught" the bowel movement in her left (gloved) hand. She stated she then retrieved her cell phone with her ungloved right hand, snapped a photo, and added a "sarcastic" text that read: "I love my job." Staff E stated her actions were immature and she wasn't thinking, but she meant no harm.</p>				
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	<p>Review of the facility's investigation revealed after the administrator arrived at the facility on 2/6/17 at 8:10 p.m., she immediately located Staff E and asked Staff E to come with her. The Administrator then asked Staff E if she had her cell phone with her and Staff E replied no, as they continued to walk to the Administrator's office. The Administrator asked if Staff E had sent a Snapchat of Resident #1's BM. Staff E confessed she had and provided the Snapchat log at the Administrator's request. The Administrator then escorted Staff E to retrieve her personal belongings and then out of the building.</p> <p>Further review of the Administrator's written investigation narrative revealed on 2/17/17, the facility terminated Staff E. At that time, the Administrator asked Staff E to whom she had sent the Snapchat and also if anyone took a screen shot. Staff E provided 6 names and replied she didn't think anyone took a screen shot. The Administrator then asked if Staff E understood the seriousness of her actions. Staff E confirmed she did; she stated she felt bad and knew she would have to live with her actions.</p> <p>The facility's "Updated Abuse Policy" dated 11/28/16</p>				
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	<p>informed staff regarding “Some of the more significant policy revisions” that included the following:</p> <p>*Additional staff training requirements included procedures for identifying and reporting activities that constitute abuse neglect, exploitation, and misappropriation of resident property. The requirements also included information related to dementia management and resident abuse prevention.</p> <p>*The abuse definition had been broadened and policies had to require all allegations of abuse neglect, exploitation or mistreatment, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required for resident medical treatment to be reported. This included verbal, sexual, physical, and mental abuse including abuse facilitated or enabled using technology.</p> <p>*The new abuse definition also included that “Instances of abuse of all residents irrespective of any mental or physical condition caused physical harm, pain, or mental anguish.” Facilities should not rely on a lack of resident reaction (e.g. – agitation, crying, or tearfulness) to determine that abuse did not occur for the purpose of reporting.</p>				
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	<p>*New definitions of "exploitation," "sexual abuse," and "mistreatment" were added.</p> <p>The undated facility policy titled "Personal Blogging Social Media and Confidential Information" included the following direction for staff.</p> <p>* You may not post resident, vendor or co-worker information which is otherwise prohibited from release by state or federal law. Examples include but are not limited to:</p> <p>* Prohibiting the use of photographs or recordings in any manner that would demean or humiliate a resident(s); including but not limited to using any type of equipment (i.e.: cameras, smart phones and other electronic devices) to take, keep or distribute photographs and recordings on social media.</p> <p>* Demeaning or humiliating photographs or video of nudity, exposed bodily (sic) parts, such as genitalia, breast, or of posting examples of bodily functions such as toilet use, provisions of incontinence care, and exposing perineal areas and/or fecal material on body parts or bedding/ furnishings.</p>				
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	FACILITY RESPONSE:			
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