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	165373	A. BUILDING _____ B. WING _____	C 03/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGVIEW HOME, INC	1010 LONGVIEW ROAD MISSOURI VALLEY, IA 51555

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F 000	INITIAL COMMENTS The following deficiencies are the result of a incident investigation 66585-I completed 3/16/17 & 3/20/17. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 223 SS=G	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 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 symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy, and interviews, the facility failed to ensure 1 of 6 residents received kind and considerate care at all times and had been free from mental abuse. Staff interviews revealed while Resident #1 had been sitting on the toilet, Staff G made a video recording of Resident #1's bowel incontinent accident that was on the floor. Staff interviews revealed Resident #1's leg had been visible in the video. Staff interviews revealed Staff G posted the video recording on a social media site Snapchat sharing the video with Staff E and Staff A. Resident #1 did not recall the incident and a reasonable person would feel humiliated,	F 223	Past noncompliance: no plan of correction required.	

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

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F 223	Continued From page 1 degraded, and experience mental anguish knowing a staff had recorded their bowel incontinent accident while he/she had been sitting on the toilet and then shared the video on social media/with others. The facility failed to ensure staff displayed respect for Resident #1 when Staff G shared the video recording with others and Staff A then showed the video to two other staff (Staff C and Staff D). The facility reported a census 110 residents. Findings: The Minimum Data Set (MDS) assessment dated 1/4/17, identified Resident #1 had been diagnoses with non-Alzheimer's dementia and depression. The MDS indicated the resident needed limited assistance of 1 staff with transfer and toileting and frequently incontinent of urine. The MDS balance during transition and walking revealed Resident #1 did not walk or could not turn around and face the opposite direction while walking. A Brief Mental Status (BIMS) documented a score of 11. A score of 11 represented moderate cognitive impairment. Resident #1 used a wheelchair for mobility. A care plan with a focus area dated 4/87/16 identified alteration in activities of daily living (ADL) function and needed staff assistance. Resident #1's care plan directed staff to assist with transfer/s and toileting. The care plan identified Resident #1 had Major Depressive Disorder (MDD) with psychotic symptoms, anxiety disorder, and dementia with behavioral disturbance. The resident's diagnosis of depression was changed to MDD with psychotic symptoms on 12/29/15. The care plan identified Resident #1 had altered thought	F 223		

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F 223	Continued From page 2	F 223		

process/cognitive loss, and the resident's physician determined the resident's dementia with behavior disturbance was an appropriate diagnosis.

Progress notes dated 3/1/17 at 4:57 p.m. documented the resident received Magnesium Hydroxide Suspension 800 milligrams (mg)/5 milliliters (ml) - give 30 ml as needed for the prevention of constipation, and to promote a bowel movement.

The facility's investigation dated 3/2/17 identified Staff F had provided cares for Resident #1 when the resident had an incontinent episode of feces on the bathroom floor. Staff F asked Staff G to assist the resident while she left to obtain more supplies (and clean off her shoes).
A facility investigation revealed at approximately 8:00 p.m. Staff G, a certified nursing assistant (CNA) recorded a video of loose stool [feces] in the bathroom. Allegedly, the video showed visible stool [feces] on the floor and a part of Resident #1's leg. According to staff reports, the video was then Snapchatted to two other employees.
The facility's investigation identified Staff A reported she had received a Snapchat from Staff G on 3/1/17. The video showed loose feces on the floor and a part of the resident's leg. Staff A asked Staff G who the resident was in the video. Staff G identified Resident #1 by his/her first name. She responded "oh nice" and concluded the conversation.
The investigation revealed Staff C (CNA) reported she saw the Snapchat video on Staff E's, CNA phone. She reported Staff E shared the video with her and Staff D, CNA while they were on break.
On 3/2/17 at 3:00 p.m. Staff B, certified medication aide (CMA) reported she witnessed

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F 223	Continued From page 3 staff in the hallway discussing an incident that took place in the resident's bathroom. She asked staff what they were doing and Staff G, CNA showed her a video of feces on the floor which included a portion of Resident #1's leg. She directed staff to get back to work and they shouldn't being doing this. [Staff B notified the DON the next day and the facility timely reported the incident to the State Agency.] As part of the facility's investigation Staff G reported he went into the resident's room after another CNA stated "there had been a big mess on the floor". Staff G reported he took a Snapchat video of the mess [bowel incontinence] and sent the video to two (2) other staff. Staff G reported the video had not been saved to his phone and was unaware if any other staff had seen the video. On 3/20/17 at 12:34 p.m., Staff F, CNA stated she worked the evening shift on 3/1/17. She had gone into Resident #1's room as he/she needed to use the bathroom. Staff F assisted Resident #1 from the bed and transferred him/her to a wheelchair. Staff F then assisted Resident #1 to the bathroom and to a standing position and lowered the resident's pants and brief. She started to assist the resident with sitting on the toilet when the resident became incontinent of bowel on the floor, and on her clothing (pants, socks and shoes.) Staff F assisted the resident with sitting on the toilet and called Staff G to stay with the resident so she could leave to clean her shoes and clothes. Staff G left the resident's room as soon as she had returned. Staff F cleaned the floor and dressed the resident in clean clothes. Staff F reported she had not been in the room when Staff G had taken the video. She reported she had not been sent the video or seen the video.	F 223		

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F 223	Continued From page 4 During an interview dated 3/20/17 at 9:00 a.m., Staff A reported she did not work at the facility on 3/1/17 but received a Snapchat photo from Staff G around 8:30 p.m. to 9:30 p.m. Staff A reported the photo showed a resident's thigh and knee [Resident #1] and loose feces on the floor. The Snapchat had written message, "A resident had a blowout". Staff A reported she texted Staff G and asked who the resident was in the photo and Staff G responded with Resident #1's [first] name. During an interview dated 3/20/17 at 12:55 p.m. Staff C reported she had been on dinner break with Staff D and Staff E [on 3/1/17]. They were sitting at a table in the breakroom when Staff E shared the video with them. The video showed feces on the floor and toilet seat. Staff C reported the video had been inappropriate and wanted nothing to do with it. She reported she got up from the table and left the area. During an interview dated 3/20/17 at 9:50 a.m., Staff B reported she worked the evening of 3/1/17 as the medication aide on C-hall. She heard Staff F, CNA & Staff G, CNA telling other CNA's about Resident #1's diarrhea incident. Staff B stated Staff G walked up to her and showed her a video. Staff B reported Staff G laughed and said the resident had a "huge mess" and Staff F shoes had feces on them. The next day she reported the incident to the Director of Nursing. Staff B reported the resident is continent of bowel but had received a laxative earlier that evening and needed staff assistance for toileting. During an interview, Staff G, Certified Nurse Aide (CNA) stated on 3/20/17 at 2:10 p.m., he had	F 223		

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F 223	Continued From page 5 been working at the facility for approximately 6 months. Staff G stated he routinely worked with Resident #1. Staff G stated the evening shift of 3/1/17 had been stressful and they were short 2 staff. While he walked down the hall, Staff F asked him for help. When he entered Resident #1's room, he saw Resident #1 resident standing in the bathroom with his/her pants and briefs around his/her ankles. Staff G stated he took a short video, recording of the floor from the sink to the toilet. Staff G did not remember if the video included a portion of the resident's body however he remembered both Resident #1 and Staff F being present during the video recording. According to Staff G, other staff came in and looked at the bathroom; though he can't remember who. Staff G stated he sent a Snapchat video and text message saying "The Daily Life of a CNA" to Staff A & Staff E. Staff G stated he used poor judgement in making a video and sharing it with others. He reported the incident was, in a way, funny. During an interview dated 3/16/17 at 1:45 p.m. the Director of Nursing reported Staff G stated he didn't know why he took the video [of Resident #1]. The DON stated she expected staff, including Staff G to perform their duties in a professional manner. The DON stated she expected staff to follow the facility's policy not to take photos or videos of residents. She stated Staff G used poor judgement when he took the video of Resident #1 and the incontinent episode. According to the Employee Recognition Report Concern Report dated 3/3/17, Staff G had taken a video of a resident [Resident #1] bowel moment that showed a small portion of the resident's	F 223		

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F 223	Continued From page 6 leg-knee area. Staff G had shared a video with co-workers. Staff G documented he was unaware of the extent of his actions. Snapchat is a video messaging application whereas using the user can take photos, record videos, add text and drawings. The sent videos are known as "Snaps."Snapchat community guidelines directed their users to keep it legal and directed users to not take Snaps of people without their knowledge or consent. The community guidelines address invasion of privacy and urged their users to not take Snaps of people not to violate their privacy in spaces, like bathrooms. The community guidelines did not address humiliation. The facility investigation revealed all staff had been educated on the new abuse policy on 9/9/16. Staff were again re-educated on the new abuse policy on 12/20/16. The facility's Abuse Prevention, Identification, Investigation and Reporting Policy dated 12/21/16, identified all residents had the right to be free from abuse and should not be subject to abuse by anyone including but not limited to the facility staff. The policy identified mental abuse is not limited to humiliation and mistreatment meant inappropriate treatment of a resident. The policy educated nursing facility staff were prohibited from taking or using photographs, recording/s in any manner that would demean or humiliate a resident. The policy revealed the following under the Federal Certification Guidelines: distribution of photographs or recording on social media which showed a resident in a compromised position, including showing the limbs or labeling a	F 223		

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F 223	Continued From page 7 resident's picture, providing comments, keeping unauthorized photographs, recordings or distribution through multimedia and or social media networks. The policy noted for resident to resident abuse, the facility will presume instance of abuse caused mental anguish in residents with cognitive impairments which may result in a resident unable to communicate mental anguish in the absence of evidence to the contrary. The facility investigation dated 3/2/17 identified the following: Resident #1 had been assessed for physical injuries with no concerns noted. When interviewed, Resident #1 did not recall any situation from the prior evening of staff being inappropriate. The resident's legal representative had been notified. Staff G had been immediately removed from working with residents. Any staff involved with this situation were verbally counselled by the DON on 3/2/17 and the abuse policy was reviewed with them on 3/3/17. The quality assurance (QA) nurse re-trained all staff from 3/2/17 to 3/6/17 on reporting allegations of abuse timely and the abuse policy regarding the Federal definition of Abuse. All staff were provided a copy of the abuse policy specifically the Federal definition section on mental abuse/taking photograph/s and or making a recording that depicted a resident in a demeaning manner while toileting, showering, showing a body part of a limb/s, labeling a resident's picture and or providing comments that would show a resident in a comprising position. The facility continued to monitor staff regarding the abuse policy. The investigation identified the facility corrected the noncompliance prior to the arrival of this	F 223		

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F 223	Continued From page 8 investigation and there was sufficient evidence the facility was in substantial compliance on 3/6/17.	F 223		