STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165559	A. BUILDING _____ B. WING _____	C 04/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENNOBLE SKILLED NURSING AND REHABILITATION CENTER	2000 PASADENA DRIVE DUBUQUE, IA 52001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Amended on 8/4/17. The scope and severity lowered from "J" to a "D" Correction Date_____ The following information is related to investigation of Complaint # 67248-I which was substantiated with a deficiency. See code of Federal Regulations (45 CFR) Part 483, Subpart B-C.	F 000		
F 223 SS=D	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 record review, staff interviews and review of policy and procedures, the facility failed to ensure the staff treated residents with dignity and respect and free from abuse when caring for or talking about them by telephone social media live streaming (Resident #1, #2). The sample consisted of 4 residents and the facility reported a census of 68 residents. According to the facility	F 223	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/05/2017

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investigation, on March 29, 2017 they [the facility] received a report that Staff A, CNA (Certified Nurse's Aide), an employee of the facility, posted live video feed on Instagram, a social media account, and delivered this live streaming to 7 friends/people without knowledge or consent of the residents. The live video consisted of a conversation with Resident #2. Staff A stated she was going to a co-worker's grandma/grandpa room. The conversation included the staff took the resident to the toilet. The resident voiced she had soiled her sock and needed it changed. The resident's face was shown while in bed. The facility investigation indicated Staff B, Dietary Aide, observed the live video on Instagram on 3/28/2017, at approximately 9:30 p.m. and reported it to the facility the following day. Staff A took an Instagram of Resident #1's name plate outside of the door and shared with social media. On 3/30/17, the facility provided training to staff regarding the Social Media policy.

Findings Include:

1. Resident #2 had a MDS (Minimum Data Set) assessment with a reference date of 3/30/2017. The MDS indicated Resident #2 had no cognitive impairment and required assistance of staff to transfer and did not ambulate. The resident had diagnoses including a left femur (thigh bone) fracture.

The Incident Tracking System reported on 3/28/2017 at approximately 9:45 p.m., the CNA (Certified Nurse's Aide) had activated a cell phone live streaming Instagram to 7 people when taking care of a resident. The people had access to hear or see live streaming. The Instagram enabled them to hear a resident in the

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background talking and a picture of the resident's face. The facility notified the resident's family and physician on 3/30/2017.

During an interview on 4/13/2017 at 8:30 a.m., Staff E, Administrator, reported Staff B, dietary personnel, observed Staff A, CNA live stream on Instagram while at work on 3/2/2017. Staff B reported viewing video of the nurse's station, Resident #1's room name plate, and mentioned Resident #2 name and viewed his/her face. While Staff A assisted Resident #2 to the bathroom, the phone faced the ceiling during cares, however viewers could hear the conversation.

On 4/18/2017 at 9:40 a.m., the Director of Nursing (DON), was interviewed and stated she became aware when Staff B reported the incident the following day. The DON stated Staff B observed Staff A on Instagram posting a live stream while at work. Resident #1's name plate could be seen and she mentioned Resident #2 by name and someone's grandma/grandpa. Staff A assisted Resident #1 to the bathroom and viewers could hear the conversation that included the resident telling Staff A that he/she soiled his/her sock and needed it changed. Later Staff A showed the resident's face while in bed. The DON stated the resident's family member requested her/his mother not know about the phone being turned on.

During a phone interview on 4/18/2017 at 11:45 a.m., Staff B stated she worked 3/28/2017 from 12:30 - 7:00 p.m. At about 9:45 p.m., she received a Social Media notification that Staff A posted live video. Staff B knew that Staff A worked that evening. Staff B observed video that included Resident #1's name plate with room

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number. Staff B also heard Staff A mention Resident #2 by name and video of the resident's face after Staff B assisted the resident to bed. While Staff A assisted the resident to the bathroom, Staff B heard conversation that included the resident telling Staff A he/she soiled self and had a sore bottom.

On 4/18/2017 at 11:00 a.m., Staff A, CNA, with mother present, reported on 3/28/2017, near the end of the shift she sat near the back dining room with her phone on Instagram, live video, a Social Media account with approximately 7 friends viewing. Staff A stated she thought she had paused the video and went to check if staff working in the front of the building needed help. Staff A went to Resident #1's room and asked Staff F if she wanted Staff A to answer Resident #2's call light. Staff A went to Resident #2's room and placed the phone on the dresser, not realizing the phone remained on. Staff A assisted the resident to the bathroom and they discussed Resident #2's relative whom Staff A knew. Staff A assisted the resident to bed. The resident asked Staff A to tell the nurse the resident needed foot wraps changed. Staff A stated she did not realize she had shown the resident's face while in bed. There were approximately seven friends following the live video streaming at the time including Staff B, Dietary Aide. After Staff A left the resident's room, she went to the break room, clocked out and left the facility. Staff A clicked the phone "live again" which meant starting the video again and not resuming it. Staff A indicated the facility terminated her due to privacy violation. Staff A worked at the facility since 2/15/2017 and signed the Corporate Compliance of Commitment to Standards and Ethics and the Social Media Policy on 2/15/2017.

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During a phone interview on 4/18/2017 at 12:30 p.m., Staff F, CNA, reported working the evening of 3/28/2017. Near the end of the shift Staff F assisted Resident #1 when Staff A came and asked if he/she could assist Resident #2 from the toilet to bed. Staff F agreed. When Staff F completed cares on Resident #1, she checked on Resident #2 and observed the resident in bed.

The policy and procedures titled Social Media Policy, revised and effective 8/16/2016 included:

Purpose: The purpose of this policy is to provide guidelines covering Social Media.

Social Media: covered by this policy includes both internal Social Media viewable only by Covenant Care audiences and external Social Media visible to third parties.

Policy:
All employees and Contingent Workers are personally legally responsible for the content of the commentary they post using Social Media and can be held liable for unlawful actives. Such improper activities could also result in disciplinary action up to and including termination of employment.

2. Resident #1 had a MDS (Minimum Data Set) assessment dated 3/15/2017. The MDS identified Resident #1 had no cognitive impairments and required extensive staff assistance for transfers and did not ambulate. The MDS documented the resident had diagnoses including quadriplegia (loss of function of all 4 limbs).

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The Incident Tracking System reported on 3/28/2017 at approximately 9:30 - 9:45 p.m. indicated the resident's room number and name were displayed on social media. On 3/30/2017 the facility notified the resident and the resident's physician.

During an interview on 4/13/2017, the resident stated the facility informed him/her of the incident and the resident voiced he/she had no concerns the room name plate was shown on social media.

The policy and procedures titled Resident's Rights, revised 6/2015 included the following;

Policy: It is the policy of Covenant Care and its subsidiaries to provide our residents with a comfortable, private and safe environment in which to live.

Terms:
A. Each resident must be treated with respect. Residents have the right to be free from all forms of physical, mental and verbal abuse. Employees are expected to protect the rights of each resident at all times.

B. Each resident is entitled to their privacy. All medical and personal records must be kept confidential. Any unauthorized access or publicizing of personal, medical or confidential information is strictly prohibited. Residents have the right to approve or refuse to have their records released to anyone outside of the facility, except in transfer to another health facility, or as required by law or third-party payment contract.

D. Covenant Care expects every resident to be treated with consideration and full recognition of

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dignity and individuality, including privacy in treatment and care of personal needs.

E. Any infringement of the comfort, privacy and personal safety of a resident will result in disciplinary action up to and including termination.

The policy and procedure titled, Abuse, Prevention, Intervention, Investigation and Crime Reporting, revised September, 2011 included:

Policy: It is the policy that every resident has the right to be free from verbal, sexual, physical and mental abuse, neglect, corporal punishment and involuntary seclusion. Any form of mistreatment of residents including but not limited to abuse, neglect, exploitation, involuntary seclusion or misappropriation of property is strictly prohibited.

Note: On 3/3017, the facility provided inservice training about social media policy and procedures which were added to the abuse policy. The facility implemented a form titled Audit Tool. This tool will ensure audits are completed to ensure phones are not present on the staff during scheduled hours and staff are able to verbalize the Social Media Policy.