STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165461	A. BUILDING _____ B. WING _____	C 07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWKEYE CARE CENTER MARSHALLTOWN	2401 SOUTH SECOND STREET MARSHALLTOWN, IA 50158

(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 VKR 8/14/17	INITIAL COMMENTS Correction date 7/22/17 The following deficiency was the result of the investigation of mandatory #68205 & incident #69044. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C). Complaint #68233 was not substantiated.	F 000	See attached document	
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 observation, clinical record review, staff and resident group interview, resident rights and facility policy review, the facility failed to assure 2 of 4 residents were free from abuse (Resident #2 and #3). The facility also failed to ensure each resident was treated with respect and full recognition of their dignity and individuality. A staff member sent humiliating photographs of Resident #2 and #3 via a social media app called, "Snapchat." Staff B admitted she sent the photos of the residents via	F 223		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bobbi Hollis	Administrator IT	7/20/17

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166461	A. BUILDING _____ B. WING _____	C 07/21/2017

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HAWKEYE CARE CENTER MARSHALLTOWN	2401 SOUTH SECOND STREET MARSHALLTOWN, IA 50158

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F 223	Continued From page 1 Snapchat. Record review revealed the residents displayed cognitive impairments and required staff assistance for personal hygiene and toilet use. A reasonable person in today's society would be embarrassed and feel degraded if his/her care provider humiliated him/her in this manner. The facility identified a census of 74 residents. Findings include: A Minimum Data Set (MDS) assessment form dated 5/3/17 indicated Resident #2 had diagnosis that included a urinary tract infection (UTI), non-Alzheimer's dementia and dysphasia. The assessment indicated the resident experienced severe cognitive impairment, required assistance of 2 staff with bed mobility, transfers, toilet use and personal hygiene. The MDS documented the resident as non-ambulatory (did not walk) and with an indwelling catheter for urinary elimination. Review of the resident's Care Plan revealed the resident had focus areas that included an impaired ability to perform activities of daily living (ADL's) related to numerous cancer diagnosis, colostomy, weakness, memory loss, hypertension, aortic stenosis, hospice status and peripheral vascular disease (PVD) (initiated 9/29/14) and with a catheter (initiated 5/15/17). The Care Pan described the resident as forgetful and directed staff to provide catheter care two times a day (BID) and as needed (PRN). An Order Entry form dated 4/20/17 directed the staff to place a 16 French (FR) 10 cubic centimeter (cc) Foley catheter changed monthly and PRN. An order form dated 5/15/17 directed the staff to	F 223		

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	165451	A. BUILDING _____ B. WING _____	C 07/21/2017

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HAWKEYE CARE CENTER MARSHALLTOWN	2401 SOUTH SECOND STREET MARSHALLTOWN, IA 50158

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F 223	Continued From page 2 discontinue the catheter. An MDS assessment form dated 5/10/17 indicated Resident #3 had diagnosis that included non-Alzheimer's dementia. The assessment indicated the resident experienced severe cognitive impairment and required extensive assistance of 2 staff with personal hygiene. A Care Plan with a focus area initiated indicated the resident had a diagnosis of dementia and at times became confused. During an interview 7/19/17 at 8:40 a.m., the resident indicated he/she could not recall anyone having taken a picture of him/her. Snapchat is a video messaging application that enables the user to take photos and record videos and add text and drawings to them. Staff A, Certified Nursing Assistant (CNA) provided the following written statement: On my first day while I walked the halls doing rounds Staff B, CNA opened a Snapchat of what seemed to have been Resident #2 with a Snapchat filter on his/her face. Then on April 25, 2017 around noon, I received a Snapchat from Staff B which had been of video of Resident #2 as he/she lay in bed on his/her side with no brief in place. The caption of the Snapchat was "F----ing third shift!" Staff B explained in the video how the catheter would not function properly positioned over the resident's hip in that way. She then proceeded to show the bypass positioned on the chuck (bed pad) located under the resident. In the Snapchat, I could see the resident's "butt cheek," but not his/her genitalia, rectum or face. I	F 223		

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F 223	Continued From page 3	F 223		

could hear the resident mumbling in the back ground. I turned this in to the Administrator while I worked at around 4 p.m. I then went on break right about that time and when I checked my phone, I had received another snap of the staff member with another resident. That picture had been of the staff member with a fully clothed resident and a face swap of the resident's face but his/her body and the face of staff C, CNA. When Staff A looked at Staff B she said "Don't tell."

The Administrator provided the following typed statement as dated:

On April 25, 2017 at 4:05 p.m. Staff A came to my office and spoke to me. She reported she witnessed Staff B open a Snapchat that had a video of what appeared to have been a resident with a Snapchat filter over his/her face. She also reported she received a Snapchat from Staff B with a video of Resident #2. I asked her how she knew it had been Resident #2 and she said "I could just tell by his/her catheter" because he/she had been the only resident on that hall with a catheter. She reported that in this video you could not see the resident's face but the video was depicting the improper placement of his/her catheter tubing with a message that said "stupid f (explicit) night shift". When interviewed I asked her if you could see the resident's, face or genitals and she indicated no but she could see the resident's right "butt cheek. At the time of this report Staff B had no longer been in the facility or in contact with any residents. On the same day, while I interviewed Staff A she received an additional Snapchat from Staff A with a picture of Staff A and what appeared to have been a resident in a wheelchair with the face of Staff C

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F 223	Continued From page 4 over the resident's face. Based on the positioning of the resident in the wheelchair and his/ her stature it appeared to have been Resident #3. I took a written statement from Staff A at that time. I called Staff B at home to discuss this matter. Staff B denied having received any Snapchat with a resident in the video. She did however acknowledge that she sent the Snapchat video with the catheter placement for the purpose of showing that the night shift had been stupid. She also acknowledged having taken and sending the Snapchat photo of her and a resident with the face swap of Staff C. I asked her if Staff C had been present for that photo and she said no, the photo she used of the Staff C had been her phone already. I asked both Staff A and Staff B what their personal relationship had been and they both indicated that they were merely classmates. I asked Staff B if she recalled the education that I provided to her on 4/20/17 regarding dependent adult abuse and the taking and/or distributing of photos or videos of residents. She said yes and that she didn't know why she sent the picture and video. During an interview 7/18/17 AT 3:56 P.M., Staff B confirmed she worked 4/25/17 from 6 a.m. until 2 p.m. That morning while her partner Staff C, CNA gave another resident a shower she entered the room of Resident #2 to get him/her up for the day and found him/her awake and trying to get out of bed as she thought the resident's foot had been on the ground with the catheter tubing around an unknown leg and under him/her pulled tight with no urine in the catheter bag. The resident wore a shirt or gown but no pants and/or a brief. At that point she opened Snapchat on her telephone because she wanted to show the Quality Assurance (QA) nurse and took a picture	F 223		

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F 223	Continued From page 5 and a 2 second video of the resident's leg however she had been 99.9% sure the residents bottom had not been exposed in the photo. The staff member indicated she could not recall who she sent the Snapchat to and that she could not recall having sent it however she recalled having typed a capture about the night shift but could not recall exactly what had been said in the capture. The staff member indicated the resident had not been aware she took the picture. The staff member also indicated around 1:55 p.m. the same day there had been nothing much to do so she went to the room of Resident #3 to chat with him/her and performed a grooming procedure at which time the staff member put Snapchat on her telephone and took a picture of the resident. The staff member then covered the resident's face with a picture of Staff C and sent it to Staff A and nobody else. The staff member felt the resident had been aware the picture had been taken. During an interview 7/19/17 at 8:40 a.m., Resident #3 indicated he/she had not recalled anyone taking a picture of him/her. A Resident's Bill of Rights form updated 11/28/16 included the following information: a. Each resident had the right to considerate and respectful care and to have been treated with honesty, dignity, respect in a manner and in an environment that promoted maintenance or enhancement of his/her quality of life and with reasonable accommodation of individual needs expect where the health, safety, or rights of the resident or other individuals in the facility would have been endangered. b. Each resident had the right to have been	F 223		

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F 223	Continued From page 6 free from exploitation, physical, verbal, sexual or mental abuse, corporal punishment and involuntary seclusion. A Hawkeye Care Centers Employee Handbook form revised 1/1/14 included the following information: a. Unless authorized by management, use of personal cell phones had been prohibited at work and on work facilities, except during break times and in the companies designated break room (s). b. Use of cameras or video recording devices had been prohibited at work at all times. Pictures and video could not have been taken at work or on work premises. c. You may not post resident, vendor or co-worker information which would have been otherwise prohibited from release by state or federal law. Review of an Abuse Prevention, Identification, Investigation, and Reporting Policy form revised 4/1/17) included the following information: a. All Residents had the right to have been free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion and any physical or chemical restraints not required to treat the resident's medical symptoms. That included prohibiting nursing facility staff from taking or using photographs or recordings in any manner that would have demeaned or humiliated a resident and prohibited using any type of equipment (e.g., cameras, smart phones and other electronic devices) to have taken, keep or	F 223		

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F 223	Continued From page 7 distribute photographs and/or recordings on social medial or through multimedia messages. b. The transmission, display or taking of electronic images of the unclothes breast, groin, buttock anus, pubes or genitals of a dependent adult by a care taker for a purpose not related to treatment, care monitoring, assessment or diagnosis or as a part of an ongoing investigation. c. Personal degradation of a dependent adult meant a willful act or statement by a caretaker intended to shame, degrade, humiliate or otherwise harm the personal dignity of a dependent adult or where the caretaker knew or reasonably should have known the act or statement would cause shame, degradation, humiliation or harm to the personal dignity of a reasonable person.	F 223		

Plan of Correction Date 7/22/2017

F223

The facility denies that the alleged facts as set forth constitute a deficiency under interpretations of federal and State law.

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of the deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of State and Federal law require it.

Without waiving the foregoing statement, the facility states that with respect to resident #2 and #3 and all similarly situated residents and the taking or dissemination of unauthorized resident photographs, the facility will ensure that all residents are free from abuse and resident dignity is preserved:

1. Update electronic communication policy to eliminate the possession of personal cell phones by employees unless in designated break areas or unless authorized by the facility Administrator or DON for emergency purposes (7/20/2017)
2. The facility has designated the break room for staff to keep their cell phones during working hours (7/20/2017)
3. Administrator or designee will educate staff of new policies and consequences (7/22/2017 and ongoing)
4. Administrator or designee will conduct periodic audits throughout the facility in all departments and shifts to ensure compliance of policy (ongoing)
5. Administrator or designee will conduct periodic interviews with residents and family members to ensure compliance with policy. (ongoing)
6. Administrator or designee will conduct periodic audits as well as resident interviews to ensure resident dignity is preserved (ongoing)

Compliance will be monitored by the facility's Administrator or designated representatives through periodic audits. The Administrator or designated representative will also audit compliance as part of the facility's quality assurance program.

Date of correction for this deficiency 7/22/2017