STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255314	A. BUILDING _____ B. WING _____	C 12/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CARE CENTER	**1920 LISA DRIVE EXTENDED GREENVILLE, MS 38703**

(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 A COVID-19 Focused Infection Control Survey, along with complaints (MS #17371 and MS #17273), was conducted by the State Agency (SA) from 12/21/20 to 12/22/20. During the survey, the SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA substantiated MS # 17371 and MS # 17273 for Resident Rights related to privacy and cited F583. The census at the time of the survey was 43.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.	F 583		2/25/21

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

Electronically Signed | 01/21/2021

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F 583	Continued From page 1 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, the facility failed to ensure the privacy for residents as related to a video and a picture that was posted on a personal social media for two (2) of 43 residents (Residents #1 and #2). Findings include: Record review of the facility policy titled "Cell Phone/Electronic Communication Devices Policy (Facility Personnel)", dated 7/19, revealed under the section titled "Prohibited Actions" revealed any use of Cell Phones to record or take still or video pictures of the facility, employees, residents, or property is strictly prohibited, and such activity may subject an employee to disciplinary action up to and including termination. Uploading resident PHI (personal/protected health information), videos, photos, or other private information to social media including but not limited to Facebook, Snapchat, Instagram, Twitter, etc. shall subject employee to disciplinary action up to and including termination. Noted signature of Certified Nursing Assistant (CNA) #1 at the bottom of the policy with the date of 3/12/20, also signed by the facility representative signature.	F 583	F583 1. Administrator was notified of video circulating on social media of Resident #1 by Resident #1 family member on 10/20/2020. Administrator was notified of photo circulating on social media of Resident #2 on 10/21/2020. Staff Development Nurse and Assessment Nurse assessed Resident #1 on 10/20/2020 and noted no adverse side effects related to video on social media. Staff Development Nurse and Assessment Nurse assessed Resident #2 on 10/21/2020 and noted no adverse side effects related to photo on social media. Administrator initiated incident report procedures and notified resident physician and resident representative. 2. Forty-five (45)of(45) residents were identified by the Director of Nursing and the Administrator to have potential to be affected by this deficient practice on 10/20/2020 and 10/21/2020. 3. An in-service was conducted on 10/20/2020 by the Director of Nursing and	

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F 583	Continued From page 2 On 12/22/20 at 8:30 AM an interview with the Administrator revealed the facility was called by Resident #1's niece on 10/20/20 and made aware of the video that was posted on a personal Facebook account of her uncle. The Administrator revealed CNA #1 was hired in March 2020 and terminated in May 2020, the video was not known of until 10/20/20 so the facility has no idea when the video was taken. The Administrator was also made aware on 10/21/20 a "selfie" picture taken by CNA #1 of Resident #2. The Administrator revealed it is against facility policy to take pictures or videos of any residents and new hires are educated on this policy. The Administrator revealed CNA #1 was terminated on 5/14/20 for an unrelated incident of leaving during a shift and not returning. On 12/22/20 at 9:30 AM an interview with Resident #2 revealed he could not recall ever having his picture taken. On 12/22/20 at 11:15 AM an interview with the Director of Nursing (DON) revealed she did not know about the video or picture that was posted on Facebook by CNA #1's boyfriend until Resident #1's family called to report to the Administrator. The DON questioned staff, and no one knew of the video or picture taken of Resident #1 or Resident #2. As soon as she was aware of the posting to Facebook, she in-serviced all staff on privacy policies and cell phone use. CNA #1 was terminated in May (2020) and they have no idea when the video was taken. All new hires are educated on the policy of privacy and cell phone use. The facility tried to reach CNA #1 but without success.	F 583	Staff Development Nurse on policy/procedure titled Cell Phone/Electronic Communication Devices Policy revised 7/19 with staff and was continued until all staff had been in-serviced. Quality Assurance meeting was held on 10/21/2020 with Medical Director, Administrator, Director of Nursing, Staff Development Nurse, Assessment Nurse, Medical Records Clerk, Social Services Director and Activities Director in attendance and reviewed policy/procedure titled Cell Phone/Electronic Communication Devices Policy revised 7/19 with no changes recommended. 4. Beginning 01/18/2021 rounds will be conducted by the Director of Nursing and Nurse Case Manager to ensure compliance related to the company□s cell phone use policy weekly for four (4) weeks and monthly for two (2) months by Director of Nursing and Nurse Case Manager. Findings will be recorded on the rounds flow record and maintained by the Director of Nursing. The Quality Assurance committee will address concerns identified from rounds and evaluate the monitoring completed by the Director of Nursing and Nurse Case Manager, monthly for three (3) months and make any recommendations or changes needed.	

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On 12/22/20 at 1:49 PM an phone interview with Resident #1's responsible party (RP) revealed she was notified by friends and family that a video of her uncle was on Facebook. She called her sister that was working near the nursing home and told her to go to the nursing home and make sure he was okay. The Administrator brought her uncle to the front lobby so her sister could see that he was fine. The RP revealed she was told CNA #1 and her boyfriend had a confrontation, and he was the one that posted the video CNA #1 made. The RP revealed she and her family did not know CNA #1 or her boyfriend.

On 12/22/20 at 2:08 PM an interview with the Attorney General agent revealed he had been unable to contact CNA #1 and had been told she was working as a travel CNA and was last in Texas. The Attorney General agent revealed he had a copy of a short clip of the video and stated he saw and heard Resident #1 being asked why he was on the floor by CNA #1.

Review of the Cell Phone/Electronic Communication Devices Policy, under the heading of Prohibited Actions, revealed any use of Cell Phones to record or take still or video pictures of the facility, employees, residents, or property is strictly prohibited, and such activity may subject an employee to disciplinary action up to and including termination. Uploading resident PHI, videos, photos, or other private information to social media including but not limited to Facebook, Snapchat, Instagram, Twitter, etc. shall subject employee to disciplinary action up to and including termination. CNA #1's signature is on the bottom of the page with the date of

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3/11/20. The DON's signature is on the bottom of the page as the Facility Representative Signature.

Review of the Search Results Mississippi Nurse Aides revealed CNA #1 has been certified since 2/26/20.

Record review of the Employee Warning Report revealed CNA #1 was terminated on 5/14/20. CNA #1 worked on 5/13/20 and left the facility between 5:30 PM and 6:00 PM and was never seen again. On 5/14/20 a phone call to CNA #1 revealed she was not coming back to work.

Review of the Termination Report for CNA #1, dated 5/14/20, noted it was because the employee walked out of building and stated that she was not coming back.

Review of the signed statement related to "The Mississippi Vulnerable Adults Act" revealed CNA #1 was given the information on the Vulnerable Adults Act and in-serviced on this information. CNA #1 noted she understood the steps to be taken if she suspects or witnesses an incidence of resident rights violation. The signature of CNA #1, with the date of 3/12/20, was noted.

Review of a statement presented by the DON revealed she watched the video on Facebook on 10/20/20 of Resident #1 and a picture of Resident #2. The DON identified CNA #1 as the person taking the picture and talking in the video.

Review of the Greenville Police incident report (#20064196) revealed a report was made by the Administrator on 10/20/20 a post on Facebook about Resident #1 was sent to a boyfriend of one

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F 583	Continued From page 5 of the ex-employees. The Administrator stated CNA #1 was fired months ago. Review of the Employee Acknowledgements and Authorizations revealed CNA #1's signature and initials confirming she had read, received, understood and agreed to abide by the stipulations included in the following policies, procedures, and forms. Included in the list of policies are resident rights and cell phone/electronic communication devices.	F 583		