| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING<br>B. WING | 07/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WYNDMOOR OF EVANSVILLE LLC | 6521 GREENDALE DR, EVANSVILLE, , 47711 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES... | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION... | (X5) COMPLETION DATE |
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| R 0000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Complaint IN00383954.<br><br>Complaint IN00383954 - Substantiated. State deficiencies related to the allegations are cited at R0055.<br><br>Survey date: July 7, 8, 2022.<br><br>Facility number: 010681<br><br>Residential Census: 60<br><br>This State Residential Finding is cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on July 14, 2022. | R 0000 | | |
| R 0055 | Residents' Rights - Deficiency<br><br>410 IAC 16.2-5-1.2(y)(1-4)<br><br>(y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded | R 0055 | R 055 Residents' Rights-Deficiency<br><br>What<br>corrective action will be accomplished for those | 08/02/2022 |

for at least the following:

(1) Bathing.

(2) Personal care.

(3) Physical examinations and treatments.

(4) Visitations.

Based on observation, interview, and record review, the facility failed to ensure dignity and privacy for residents. 1 of 1 employee took a video of themselves in a resident's room, posted it to social media, and 1 of 1 employee slept while on duty.(Resident B)

Finding includes

Two anonymous interviews indicated they had witnessed staff sleeping while on duty, only one staff observed sleeping was "coached" because there was a picture of them sleeping.

During an anonymous interview, it was stated that CNA 1 was suspended because she had posted a video of herself in a residents room, and other areas in the facility on social media. The anonymous staff indicated they had personally viewed the social media videos and could identify Resident B's room.

An anonymous interview indicated a CNA on third shift was observed dozing off while

residents found to have been affected by the deficient practice;

Cell phone policy revised, and all staff in-servicing completed on resident rights, social media, phone use and employee breaks.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

All residents were interviewed by management regarding inappropriate cell phone use by employees in the facility and responses documented.

What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur;

Additional educational in-service training required for all staff

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| | on duty, Administration had been made aware.<br><br>On 7/8/22 at 8:00 a.m., Resident B indicated she did not see staff with their phone out in her room taking pictures or videos. Resident B had diagnoses that included, not limited to, dementia in other diseases classified elsewhere without behavioral disturbance.<br><br>On 7/8/22 at 8:10 a.m., the Administrator indicated she had been made aware of 1 employee sleeping while on duty, and they had been written up. She further indicated she was sent texts from a former employee of videos posted on social media by CNA 1. Resident B's room and the laundry room were identified in the video, the edge of Resident B's couch could be seen. No resident or resident identifiers were in the videos and CNA 1 had been suspended for 3 days.<br><br>On 7/8/22 at 8:28 a.m., the current policy on cell phones with a date of 5/1/19, was provided by the Administrative Assistant. The policy included, but not limited to: It is the company's expectation that all cell phones will be off or silent during working hours so normal workflow remains undisturbed. Cell phones are not to be used to record or share confidential company information or use the | | including resident rights and HIPAA.<br><br>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and<br><br>Resident rights and HIPAA in-service will be completed monthly by all staff. This will be an ongoing education completed at the all-staff mandatory monthly meeting.<br><br>By what date the systematic changes will be completed.<br><br>Completion of all staff in-service and education by Tuesday, 08/02/2022. | |

company's network to download illegal or inappropriate materials from the Internet.

On 7/8/22 at 8:56 a.m., the current HIPPA (Health Insurance Portability and Accountability Act) policy with a revision date of 3/28/20, was provided by the administrative Assistant. The policy included, but not limited to: Posting unauthorized photographs of our residents, their property, or their personal information on the Internet is a violation of our obligation under HIPPA and the privacy rights of our resident. Associates who engage in such behavior may be subject to corrective action, up to and including termination.

On 7/8/22 at 8:56 a.m., an undated employee handbook page was provided by the Administrative Assistant. The page include, but not limited to: Social media conduct that reflects negatively on the Company will not be tolerated.

This State Finding relates to Complaint IN00383954.

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duty.(Resident B)

Finding includes

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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