

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165278	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/09/2025
NAME OF PROVIDER OR SUPPLIER  Living Center West		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 4th Avenue SE Cedar Rapids, IA 52403	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>48888</p> <p>Based on interviews, clinical record review, facility investigation, and facility policy review, the facility failed to protect resident's right to privacy for 1 of 3 residents reviewed for resident rights when staff took video of a resident and posted it to social media (Resident #1). The facility reported a census of 70 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment, dated 10/23/24, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderate cognitive impairment. Resident #1's diagnoses included Schizophrenia, moderate intellectual disability, and depression.</p> <p>The Care Plan, initiated 7/09/24, revealed Resident #1 had impaired cognition related to moderate intellectual disability, Schizophrenia, and Major Depressive Disorder.</p> <p>The facility submitted a self-reported incident on 11/12/24 at 10:58 to the Department of Inspections, Appeals, and Licensing (DIAL) for video of Resident #1, taken by Staff A, Certified Nursing Assistant (CNA) on 11/11/24, and posted to a social media platform (Snapchat).</p> <p>Review of the facility internal investigation revealed a statement of incident, signed and dated on 11/12/24 by Staff A. Staff A wrote that on 11/11/24, they were joking with resident while eating an ice cream cone and had asked if it was good and how he was eating it. Staff A's statement informed the video was taken at approximately 4:30 PM and the resident was joking saying no as he smiled and showed his teeth. Staff A's statement revealed the video was posted to their private Snapchat story.</p> <p>Review of an 8 second video submitted by the facility showed Resident #1 holding an ice cream cone, he appeared to be sitting in a wheelchair in the hallway and was without dentures in place. A female voice said, let me see your teeth, Resident #1 responded no, and then smiled without teeth as a female voice laughed.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Staff A personnel file revealed a document titled Confidentiality Agreement, signed and dated by Staff A on 8/16/23 which agreed not to take any photographs or recordings of residents in any nature and not post any information resident's personal or health related information on any form of social media. Staff A personnel file additionally revealed a document titled, Dependent Adult Abuse Policy Review, which attested understanding of obligation to report to supervisor any potential abuse as defined in the Abuse Prevention, Identification, and Reporting Policy, signed by Staff A and dated 8/16/23.</p> <p>Disciplinary Report Form, dated 11/14/24, revealed termination of Staff A's employment due to video taken of resident and posted to Snapchat in violation of the facility's abuse policy for personal degradation signed by the Director of Nursing and Facility Administrator.</p> <p>On 1/08/25 at 3:50 PM, Staff B, former Director of Nursing (DON), stated that on 11/11/24 at approximately 8:00 PM she received a text message, with screen-shot of the video, from Staff C, former Assistant Director of Nursing (ADON) which informed her that Staff A had posted video of Resident #1 to their Snapchat story. Staff B stated that she showed this to the Facility Administrator the following day and that the facility decided to suspend Staff A while conducting an internal investigation.</p> <p>On 1/09/24 at 09:40 AM, Staff C, former ADON, stated she had witnessed the video of Resident #1 posted by Staff A on Staff A's Snapchat story and notified Staff B through a text message. Staff C informed that Staff A did not send video directly to Staff C, but posted it to a Snapchat story in which anyone on Staff A's friends list could have seen the video.</p> <p>On 1/09/25 at 10:45 AM, Facility Administrator stated she found out about video of Resident #1 posted by Staff A on 11/12/24 around 10:00 AM, when Staff B, notified her of the incident. Facility Administrator revealed she then reported incident to DIAL and began an internal investigation of the incident which included staff and resident interviews for potential abuse, disciplinary action of Staff A, and all staff education of the facility's abuse/personal degradation policy.</p> <p>The facility policy, titled Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy, dated July 2024, revealed the prohibition of staff from taking part in acts that result in personal degradation, including the taking or using any type of equipment to take, keep, or distribute photographs and/or recordings on social media or through multimedia messages. The policy defined personal degradation as a willful act or statement by a caretaker intended to shame, degrade, humiliate, or otherwise harm, the personal dignity of a reasonable person and includes the taking, transmission, or display of an electronic image of a dependent adult by a caretaker, or where the caretaker knew or reasonably should have known the act would cause shame, degradation, humiliation, or harm to the personal dignity or a reasonable person.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>48888</p> <p>Based on interviews, facility investigation review, and facility policy review, the facility failed to report to the state agency within 2 hours of knowledge of an abuse allegation for 1 of 3 residents reviewed for resident's rights (Resident #1). The facility reported a census of 70 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment, dated 10/23/24, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderate cognitive impairment. Resident #1's diagnoses included Schizophrenia, moderate intellectual disability, and depression.</p> <p>The facility submitted a self-reported incident on 11/12/24 at 10:58 AM to the Department of Inspections, Appeals, and Licensing (DIAL) for video of Resident #1, taken by Staff A, Certified Nursing Assistant (CNA) on 11/11/24, and posted to a social media platform (Snapchat).</p> <p>Review of facility internal investigation revealed a statement of incident, signed and dated on 11/12/24 by Staff A. Staff A wrote that on 11/11/24, they were joking with a resident while eating an ice cream cone and had asked if it was good and how he was eating it. Staff A's statement informed the video was taken at approximately 4:30 PM and the resident was joking saying no as he smiled and showed his teeth. Staff A's statement revealed the video was posted to their private Snapchat story.</p> <p>Review of an 8 second video submitted by the facility showed Resident #1 holding an ice cream cone, he appeared to be sitting in a wheelchair in the hallway and was without dentures in place. A female voice said, let me see your teeth, Resident #1 responded no, and then smiled without teeth as a female voice laughed.</p> <p>On 1/08/25 at 3:50 PM, Staff B, former Director of Nursing (DON), stated that on 11/11/24 at approximately 8:00 PM she received a text message, with screen-shot of the video, from Staff C, former Assistant Director of Nursing (ADON) which informed her that Staff A had posted the video of Resident #1 to their Snapchat story. Staff B stated that she showed this to the Facility Administrator the following day and that the facility decided to suspend Staff A while conducting an internal investigation.</p> <p>On 1/09/24 at 09:40 AM, Staff C, former ADON, stated she had witnessed the video of Resident #1 posted by Staff A on Staff A's Snapchat story and notified Staff B through a text message. Staff C informed that Staff A did not send video directly to Staff C, but posted it to a Snapchat story in which anyone on Staff A's friends list could have seen the video.</p> <p>On 1/09/25 at 10:45 AM, Facility Administrator stated she found out about the video of Resident #1 posted by Staff A on 11/12/24 around 10:00 AM, when Staff B, notified her of the incident. Facility Administrator revealed she then reported incident to the state agency and began internal investigation of incident, which included staff and resident interviews for potential abuse, disciplinary action of Staff A, and all staff education of the facility ' s abuse/personal degradation policy.</p> <p>(continued on next page)</p>		

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