

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER Julian J Levitt Family Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 770 Converse Street Longmeadow, MA 01106	

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>37227</p> <p>Based on records reviewed and interviews, for two of three sampled residents (Resident #1 and Resident #2), who were severely cognitively impaired, the Facility failed to ensure Resident #1 and Resident #2's right to personal privacy was respected, when on 03/14/24, Certified Nurse Aide (CNA) #1 used her personal cell phone to participate in a non-work related, live video call, while providing care to Resident #1 and Resident #2, without the consent of the residents or their representatives.</p> <p>Findings include:</p> <p>Review of the Facility's Residents Rights Policy, undated, indicated the resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The Policy indicated that the Federal and State laws guarantee certain basic rights to all residents of the facility, these rights include the resident's right to privacy and confidentiality. The Policy indicated the Facility would make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.</p> <p>Review of the Facility's Mobile Device Use Policy, undated, indicated:</p> <ul style="list-style-type: none"> - The Facility recognizes that cellular phones and other wireless devices have become a general means of communication within our culture. This policy is to ensure there is no interference with job performance, HIPPA violations, and resident privacy with the use of cell phones. - Photo, video, or audio recording with a personal mobile device is strictly prohibited. - Mobile device usage for personal reasons is limited to before shift, after shift, and on breaks in nonresident care areas. Use of cell phones in resident care areas is strictly prohibited. <p>Review of the Facility's Internal Investigation Report, undated, indicated on 03/14/24 a staff member reported that CNA #1 answered an incoming video call while providing care to Resident #1 and Resident #2. The Report indicated that CNA #1 did not end the call and continued with resident care. The Report indicated CNA #1 confirmed during an interview, that she answered the video call, placed the phone down (on speaker mode) and continued with the call during the provision of care to Residents #1 and Resident #2.</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>A) Resident #1 was admitted to the Facility in February 2024, diagnoses included Parkinson's Disease and neurocognitive disorder with Lewy Bodies (progressive dementia that results from protein deposits in nerve cells of brain).</p> <p>Review of Resident #1's most recent Minimum Data Set (MDS) assessment, dated 02/14/24, indicated he/she had severely impaired cognitive skills for daily decision making, and that he/she was dependent on staff for activities of daily living (ADLs) and mobility.</p> <p>Review of Resident #1's Medical Record indicated his/her Health Care Proxy (HCP) was activated on 02/09/24.</p> <p>During a telephone interview on 04/10/24 at 11:18 A.M., Certified Nurse Aide (CNA) #2 (which also included a review of her written witness statement dated 03/14/23) said that while she was in the shower room on 03/14/24, she was assisting CNA #3 with getting Resident #1 to his/her chair after being weighed. CNA #2 said CNA #1 was called to the shower room to help. CNA #2 said that CNA #1 answered a video call on her personal cell phone and remained on the call in the shower room, while she assisted with care for both Resident #1 and Resident #2.</p> <p>CNA #2 said that when she and CNA #3 got Resident #1 into his/her recliner chair, he/she was agitated. CNA #2 said CNA #1 turned her phone to show Resident #1's face and said to the person on the phone, look at this [guy/girl], he/she needs to calm down. CNA #2 said she heard the person on the phone reply yeah, he/she does need to calm down!</p> <p>During a telephone interview on 04/10/24 at 11:31 A.M., Certified Nurse Aide (CNA) #3 (which also included a review of his written witness statement dated 03/14/23) said that he was not sure if CNA #1 was using her phone during care with Resident #1, because his full attention was on the resident.</p> <p>During a telephone interview on 04/17/24 at 08:02 A.M., Certified Nurse Aide (CNA) #1 (which also included a review of her written witness statement dated 03/14/23) said she was supervising residents in the dining room when at the end of the lunch meal she was asked to help the CNAs that were performing resident care in the shower room.</p> <p>CNA #1 said that after she entered the shower room, she received a video call on her personal phone from her family member. CNA #1 said she answered the video call while assisting with Resident #1, and said she turned the phone's camera toward his/her face and said to the person on the phone, look at him/her, he/she needs to calm down.</p> <p>B) Resident #2 was admitted to the Facility in September 2023, diagnoses included Alzheimer's Disease, anxiety disorder, and aphasia (a language disorder caused by damage in a specific area of the brain that controls language expression and comprehension).</p> <p>Review of Resident #2's most recent MDS assessment, dated 01/11/24, indicated he/she had severely impaired cognitive skills for daily decision making, and that he/she was dependent on staff for ADLs and mobility.</p> <p>Review of Resident #2's Medical Record indicated his/her HCP was activated on 09/21/23.</p> <p>(continued on next page)</p>		

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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>CNA #2 said that after assisting Resident #1, she returned to the bathroom to assist Resident #2. CNA #2 said she asked CNA #1 for help transferring Resident #2 off of the toilet and back into his/her wheelchair. CNA #2 said that CNA #1 entered the bathroom, while the video call on her personal cell phone was still active, and she (CNA #1) turned the phone to video Resident #2 and said, look at him/her too.</p> <p>CNA #2 said that CNA #1 then propped the phone (which was on speaker mode) on the bathroom sink while the video call was still active. CNA #2 said that she could not be sure if the person on the phone could see Resident #2 during personal care, but said she recalled hearing a female voice on the phone say, you guys look like you could use some help.</p> <p>Review of the Director of Nurses (DON) Written Summary of her interview with CNA #1, dated 03/14/24, indicated CNA #1 told the DON that she angled the camera at Resident #2 and said look at him/her before placing her phone on the sink area which was on the other side of the bathroom. The Summary indicated CNA #1 admitted she propped her cell phone up so that she could continue her phone conversation, however CNA #1 was adamant that Resident #2's care and transfer were not in view of the phone's camera.</p> <p>CNA #1 told the Surveyor she went into the bathroom to assist CNA #2 with transferring Resident #2 from the toilet back into his/her wheelchair. CNA #1 denied showing Resident #2's face on the video call and denied saying look at him/her. CNA #1 said that although the video call was still active, she propped the phone on the sink, so the camera was pointed at her (CNA #1's) back, obstructing the view of Resident #2. CNA #1 said that while the view of Resident #2 during care was obstructed, the audio was not.</p> <p>When the Surveyor asked CNA #1 if she recalled the person on the phone saying, you guys look like you need some help she told the surveyor that the comment was made by the person on the phone while she was assisting with Resident #1, not Resident #2.</p> <p>CNA #1 said she did not obtain consent from Resident #1 and Resident #2, or the Resident's Representatives, prior to including their audio and/or video during her personal video call.</p> <p>Although CNA #1 told the surveyor that she did not turn the phone's camera toward Resident #2 and say, look at him/her (as CNA #2 indicated in her interview with the DON on 3/14/24 and to the Surveyor on 04/10/24), CNA #1's statement seems suspect given her admittance to doing so, during her interview with the DON on 03/14/24, immediately following the incident.</p> <p>During an interview on 04/10/24 at 1:40 P.M., the Director of Nurses (DON) said CNA #1 should not have used her personal cell phone device in a resident care area. The DON said that after she and the Administrator interviewed CNA #1, they sent her home pending the results of the investigation. The DON said the outcome of the Facility's internal investigation was that CNA #1 had violated the privacy of Residents #1 and #2, violated Facility policy and went against the standard of care provided at the Facility.</p> <p>On 04/10/24, The Facility presented the Surveyor with a plan of correction that addressed the areas of concern identified in this survey, The Plan of Correction is as follows:</p> <p>(continued on next page)</p>		

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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>A. Facility Administration suspended Certified Nurse Aide (CNA) #1 on 03/14/24 during the investigation and terminated her on 03/15/24.</p> <p>B. On 03/14/24, Resident #1 and Resident #2 were assessed by nursing and had no ill effects from the incident.</p> <p>C. On 03/14/24, Resident #1 and Resident #2 were assessed by Social Services and found to be comfortable in their surroundings. Both Resident #1 and Resident #2 received additional support visits from Social Services on 03/15/24 and 03/16/24.</p> <p>D. On 03/14/24, since it was determined by the facility that all residents where potentially at risk to be effected by this issue, the Director of Nurses and Department Heads educated all staff regarding the Facility's Mobile Device Use Policy, Resident Rights and Customer Service.</p> <p>E. The area of concern will be reviewed at the April 2024 QAPI meeting on 04/22/24, and the committee will continue to review the issue monthly for a minimum of three months, to ensure substantial compliance.</p> <p>F. The Administrator and Director of Nursing are responsible for overall compliance.</p>		