

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2025
NAME OF PROVIDER OR SUPPLIER Maryville Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 524 North Laura Maryville, MO 64468	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195</p> <p>Based on observation, interview, and record review, the facility failed to ensure four residents (Resident #1, #2, #3, and #4) out of five sampled residents were free from abuse when three staff members took photos of four residents (Resident #1, #2, #3, and #4) and one staff member took a video (Resident #2) and posted it to social media. Two of the pictures taken had a demeaning comment written on the pictures about the residents (Resident #1 and Resident #2). Three of the four residents had a diagnosis of dementia and all four residents were unaware that they had been recorded or had their pictures taken and posted to a social media platform. The facility census was 44.</p> <p>On 3/11/25, the Administrator was notified of the past noncompliance which began on 02/10/2025. The facility administration immediately conducted an investigation and corrective actions were implemented. The noncompliance was corrected 02/28/2025.</p> <p>Review of the facility policy, Abuse Prevention, and Prohibition, revised January 2024, showed:</p> <ul style="list-style-type: none"> -Each resident has right to be free from abuse; -Residents must not be subjected to abuse by anyone, including, but not limited to , facility staff; -The facility prohibits mistreatment, neglect, or abuse of residents; -Facility staff shall be trained on the abuse prohibition program during orientation, annually, and ongoing during educational sessions, and per state regulations; -Resident abuse must be reported immediately to the administrator; -While an investigation is underway, steps will be taken to prevent further abuse; -If a person is identified in the allegation of abuse, that person will not be allowed access to the facility while the investigation is in progress except to meet with the administrator as part of the investigation; -The person identified in the allegation of abuse will have no contact with residents or other employees during the investigation process; <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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Employee allegations:</p> <p>-When an employee is the alleged perpetrator of abuse or neglect, that employee shall immediately be barred from any further contact with residents through suspension, pending the outcome of the facility investigation, prosecution, or disciplinary action against the employee. The administrator and/or Director of Nursing will relay this suspension. At that time, the alleged staff member will be advised of the allegation and encouraged to assist in completing a statement relevant to the facts. The employee shall be instructed that the suspension is without pay and will be in effect while the investigation is ongoing. The investigation and due process rights of the alleged perpetrator/s will be observed. If the allegation is found unsubstantiated, the employee will be reinstated with retroactive pay for any days missed that the employee was originally scheduled to work. If the allegation is substantiated, the employee will be terminated.</p> <p>-Reporting/Response:</p> <p>-The facility employee who becomes aware of abuse or neglect shall immediately report the matter to the facility administrator or his/her designated representative in the administrators absence.</p> <p>- Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled using technology. Technology includes any type of video or voice recording of residents, taking pictures of residents, or social media posts, unless by an authorized individual.</p> <p>- Mental Abuse includes but is not limited to, humiliation, harassment, and threats of punishment or deprivation. Mental abuse includes but is not limited to, abuse that is facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate a resident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of facility policy from employee handbook, use of cell phones and other portable communication devices, undated, showed; Unless approved for community business, the possession or use of cellular phones, pagers, or other portable communication device is strictly prohibited while on duty except during scheduled rest and meal periods. Use of these devices will be restricted to break room or outside of community. while on duty these devices will be stored in locker, purse, backpack, or vehicle. If purse/backpack stored in work area must be turned to off position. To ensure privacy of our residents, their families, and fell ow team members, the taking of photographs or audio recordings on community property is strictly prohibited without the explicit permission of administrator or executive director.</p> <p>Review of facility policy, Resident's Rights, dated 12/2024, showed:</p> <ul style="list-style-type: none"> -Each resident residing in the community had a right and will be afforded the right to a dignified existence. -It was responsibility of all who work in the community, including employees, to advocate and protect the rights of each resident; -Resident rights include: privacy and confidentiality <p>The facility did not have a policy on Health Insurance Portability and Accountability Act (HIPPA), a law enacted in 1996 that established national standards to protect individuals' medical records and other personal health information, ensuring patient privacy and security.</p> <p>1. Review of Resident #1's Annual minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 1/22/25, showed:</p> <ul style="list-style-type: none"> -Cognition severely impaired; -No behaviors noted; -Clear speech; -Made self-understood and understood others with clear comprehension; -Partial assistance with bathing and dressing; -Independent with toileting, personal hygiene, and mobility; -Diagnoses included: dementia (a group of brain disorders that causes progressive decline in cognitive function, memory, and behavior), chronic pain, and constipation. <p>Review of the residents care plan, dated 1/28/25, showed:</p> <ul style="list-style-type: none"> -Risk of constipation due to medical history, impaired mobility, and use of certain medications; -He/She had negative moods at times and made negative statements towards others; <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Staff should redirect and not draw attention to negative statements made by resident;</p> <p>-He/She was deemed incompetent to make their own decisions and Durable Power of Attorney (DPOA) was invoked;</p> <p>-All decisions should be made through the DPOA (Durable Power of Attorney);</p> <p>-He/She had memory/recall problem due to dementia diagnosis;</p> <p>-Engage the resident in conversation that is meaningful to resident.</p> <p>Review of facility progress notes showed:</p> <p>-On 2/28/25, The Administrator and Social Service designee placed a phone call to DPOA regarding a picture taken of the resident. No answer. Message left to return call. DPOA returned call and spoke to Administrator and Director of Nursing (DON);</p> <p>-On 2/28/25, a Trauma assessment was completed, the resident voiced no traumas or fears and voiced feelings of safety in the facility.</p> <p>Review of facility provided image, dated 3/5/25, showed:</p> <p>- A Snapchat Image of Resident #1 looking at camera making a peace sign with right hand. The Resident is fully dressed with a blanket over her lap sitting in a recliner in his/her room;</p> <p>-Text on the image showed 'Is there a baby in ur belly it's kinda big today'</p> <p>-Text in upper left hand of image showed Nurse Aide (NA) A and Sunday.</p> <p>During an interview on 3/11/25 at 3:15 P.M., the Administrator said he/she spoke to resident's family member via phone on 2/28/25 at 2:19 P.M. to notify them of the pictures that had been taken of the resident.</p> <p>During an interview on 3/11/25 at 4:22 P.M., Resident said:</p> <p>-He/She was not aware that staff had taken his/her picture;</p> <p>-He/She would not have wanted his/her picture to be taken and posted on social media without his/her knowledge;</p> <p>-He/She did not know anything about Snapchat;</p> <p>-He/She would have feelings about his/her picture taken about her depending on what was written under the picture;</p> <p>-If someone made a comment about her picture it would have made him/her mad about it.</p> <p>2. Review of Resident #2's Quarterly MDS, dated [DATE], showed:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 2/28/25, Administrator and social services designee placed call to the resident's guardian. The Guardian returned call at 3:10 P.M. and spoke with administrator and social services designee. The Guardian was informed of the picture and video taken and that it had been shared with others via social media. The Guardian was not concerned by this. The facility staff offered to show picture or video and guardian was unsure if he/she wanted to see either.</p> <p>-On 2/28/25, a Trauma assessment was attempted but resident unable to participate due to poor cognition.</p> <p>-On 3/6/25, the Resident's family member came to facility that morning and requested to see the picture and video taken of their loved one. The DON and social service designee met with family member in DON office and showed video and picture of resident. The Family member was not bothered by either and saw nothing wrong with the picture voicing that he/she thought the staff was just trying to have fun or maybe the Resident was giving the staff a hard time but found no harm in either picture or video.</p> <p>Review of a photograph provided by the facility on 3/5/25, showed:</p> <p>-A Snapchat photo with NA B and date of February 10 displayed in the upper left hand of picture;</p> <p>-The image shows Resident #2 looking directly at the camera wearing only a hospital gown with a bed in the background;</p> <p>-The text across the picture showed 'The look of hatred'.</p> <p>Review of an undated video recording provided by the facility on 3/5/25, showed:</p> <p>-The video was posted on Snapchat on February 10, 2025 was 13 seconds long.</p> <p>-The audio on the video showed NA B said 'Resident #2 hates me guys', then asking Resident 2 'do you hate me', resident 2 then responded 'no', NA B then asked resident #2 if he/she was sure and resident responded yes;</p> <p>-At 0:00 seconds the video was of NA B with the camera on his/her self wearing a blue surgical mask below the chin.</p> <p>-At 0:07 seconds the video pans to Resident #2 sitting in his/her wheelchair wearing only a hospital gown.</p> <p>During an interview on 3/11/25 at 3:15 P.M., Administrator said he/she spoke to the resident's family member via phone with social service designee present on 2/28/25 at 2:20 P.M. to notify them of the pictures that had been taken of the resident without proper consent.</p> <p>3. Review of Resident #3's Quarterly MDS, dated [DATE], showed:</p> <p>-Cognitive status not assessed;</p> <p>-No behaviors noted;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Clear speech;</p> <p>-Made self-understood and had clear comprehension of others;</p> <p>-Independent with personal hygiene, upper body dressing, eating, and oral care;</p> <p>-Set up assistance with lower body dressing;</p> <p>-Moderate assistance with mobility from sit to stand, lying to sitting on side of bed, rolling left and right, chair to bed or chair transfers, and toilet transfers;</p> <p>-Diagnoses included: Depression (a mental health condition characterized by persistent feelings of sadness, loss of interest, and changes in daily functioning), insomnia (a sleep disorder that made it hard to fall or stay asleep), glaucoma (eye disease that can lead to vision loss), and pain.</p> <p>Review of care plan, dated 2/25/25, showed:</p> <p>-Diagnosis of depression and history of showing signs and symptoms;</p> <p>-He/She took an antidepressant medication for diagnosis of depression</p> <p>-Had impaired vision related to glaucoma;</p> <p>-Required supervision/touch assistance transfers, dressing, and bed mobility;</p> <p>-Chose to spend most of his/her time alone in their room.</p> <p>Review of facility progress notes showed:</p> <p>-On 2/28/25, the Administrator and social service designee went to resident room to notify him/her of staff taking his/her picture. The resident asked why a picture was taken of him/her, explained that he/she did not know reasoning. The picture was shown to resident and explained that steps were being taken with a facility investigation, reporting to state agency, and employee suspension. The resident said he/she did not worry about it as it sounded like it had been handled. The resident said he/she felt his/her family member should be notified of the picture so they knew everything that was going on. The family member was notified via phone of the picture being taken and that the resident was aware.</p> <p>-On 2/28/25, a trauma assessment was attempted but resident refused to answer any questions and stated he/she did not understand why they were wanting to ask him/her about trauma and to leave his/her room if that was all they needed right now.</p> <p>Review of facility provided photograph, dated 3/5/25, showed:</p> <p>-A Snapchat image of resident sitting on the side of his/her bed with walker in front of them;</p> <p>-Resident #3 was fully clothed wearing a striped blouse, and black pants and shoes;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Resident #3 was sitting on an unmade bed with the curtains to his/her room open;</p> <p>-The upper image showed date 2/5/25 and NA D's first name.</p> <p>During an interview on 3/11/25 at 3:15 P.M., Administrator said:</p> <p>-He/She spoke to the resident in person due to him/her being their own person at that time. The resident indicated he/she wanted their DPOA to be contacted;</p> <p>-He/She contacted the resident's DPOA via phone on 2/28/25 with an undocumented time, to notify them of pictures that had been taken of the resident.</p> <p>During an interview on 3/11/25 at 3:23 P.M., the residents DPOA said:</p> <p>-The facility notified him/her regarding the resident's picture being posted to social media in a group chat;</p> <p>-The resident would not have consented to have her picture taken as he/she looked now;</p> <p>-Prior to Resident #3's illness he/she always made sure he/she looked perfect and always wore red lipstick;</p> <p>-Resident #3 would not be proud of the way he/she looked currently and would be embarrassed.</p> <p>During an interview on 3/11/25 at 4:26 P.M., the resident said he/she didn't care to talk about his/her photo being taken.</p> <p>4. Review of Resident #4's Quarterly MDS, dated [DATE], showed:</p> <p>-Cognitive status not assessed;</p> <p>-He/She used clear speech;</p> <p>-He/She sometimes understood others and was sometimes able to make others understand them;</p> <p>-No behaviors noted;</p> <p>-Dependent on a walker;</p> <p>-Substantial assistance with toileting;</p> <p>-Moderate assistance with dressing and personal hygiene;</p> <p>-Independent with most mobility;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Diagnoses included: dementia, macular degeneration (disease that damages the central part of retina responsible for sharp, central vision, leading to vision loss for tasks like reading and recognizing faces), sensorineural hearing loss (permanent hearing loss due to damage to inner ear making it difficult to hear and understand sounds), and pain.</p> <p>Review of the residents care plan, dated 12/31/24, showed:</p> <p>-He/She was unable to voice their routines and preferences, refer to my DPOA for known routines and preferences;</p> <p>-He/She wore dentures and glasses. Please ensure they were clean, proper fitting, and worn while awake;</p> <p>-He/She had history of physical behaviors during personal cares;</p> <p>-He/She may not be able to communicate fears/needs due to neuro cognitive impairment;</p> <p>-Avoid power struggles with him/her;</p> <p>-Avoid over-stimulation (examples noise, crowding, other physically aggressive residents);</p> <p>-He/She had impaired vision due to macular degeneration. Used to wear glasses but as diagnosis progressed no longer wanted to wear them;</p> <p>-He/She had been deemed incompetent to make own decisions, his/her DPOA was invoked and all decisions would be made through them;</p> <p>-He/She had difficulty hearing due to sensorineural hearing loss.</p> <p>Review of facility progress notes showed:</p> <p>-On 2/28/25, the Administrator and Social Service designee placed call to DPOA to inform him/her of pictures taken of resident by staff. The Administrator explained to DPOA the type of pictures that were taken and shared by staff with other staff members. The DPOA did not understand why facility was calling to notify him/her of such thing and question what facility needed from him/her. Explained to him/her the reason for calling and actions being put in place. The DPOA asked if the pictures were shared publicly and he/she was fine with the situation knowing that the pictures were not publicly shared.</p> <p>-On 2/28/25, a trauma assessment was attempted but resident unable to participate due to cognition.</p> <p>Review of two facility provided images of resident, dated 3/5/25, showed:</p> <p>-Snapchat Image 1:</p> <p>- The resident was observed wearing a purple house coat fully dressed reaching towards the camera and was wearing pink heart shaped sunglasses. Resident was sitting in the medication cart storage area in the middle of the memory care unit with the medication cart behind him/her.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Text in the upper left showed NA B and the date of February 14th;</p> <p>-Snapchat Image 2:</p> <p>- The resident was wearing purple housecoat, pink shaped sunglasses, and looking directly at camera making the peace sign. Resident was positioned in front of the medication cart in the medication storage area on the memory care unit.</p> <p>-Text in the upper left showed NA B and the date of February 14th.</p> <p>During an interview on 3/11/25 at 3:15 P.M., the Administrator said he/she contacted resident's DPOA with social service designee on 2/28/25 at 2:22 P.M.</p> <p>Observation on 3/11/25 at 4:29 P.M. showed resident was sleeping in his/her recliner on the memory care unit at the facility.</p> <p>5. Review of facility investigation showed:</p> <p>-On 2/28/25, CNA A sent Director of Nursing (DON) screen-shots of pictures taken of residents on snap chat that were sent in a group chat between five total CNA's or Nurse Aides.</p> <p>-Facility suspended all five CNA's on 2/28/25 including CNA A, NA A, NA B, NA C, NA D;</p> <p>-Facility provided all staff in-service on 2/28/25 regarding recording policy from employee handbook and abuse and neglect policy;</p> <p>-An on-going in-service was completed with direct care staff to include prior to working their next scheduled shift on recording policy from employee handbook and abuse and neglect;</p> <p>-On 2/28/25 all direct care staff were educated prior to working their next scheduled shift;</p> <p>-On 2/28/25 the facility conducted and quality assurance performance improvement plan meeting with the medical director;</p> <p>-Interviews were conducted with ten sampled residents related to abuse, neglect, and exploitation and no concerns were voiced by residents interviewed.</p> <p>-On 3/3/25, the Administrator implemented audits of asking two staff members per day, five days a week, for eight weeks on the facility cellular phone policy, social media policy, recording and reporting of all recording;</p> <p>-On 3/3/25, the Social Service Designee implemented audits of asking two residents a day, five days a week, for eight weeks on if they had any concerns related to being recorded;</p> <p>Review of employee files showed:</p> <p>-CNA A:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She signed abuse, prevention and prohibition policy on 12/6/24;</p> <p>-He/She signed HIPPA form on 12/6/24;</p> <p>-He/She signed the employee handbook acknowledgement form on 12/6/24;</p> <p>-He/She was suspended on 2/28/25;</p> <p>-He/She received a written warning on 3/3/25;</p> <p>-NA A:</p> <p>-He/She signed abuse, prevention and prohibition policy on 11/27/24;</p> <p>-He/She signed HIPPA form on 11/27/24;</p> <p>-He/She signed the employee handbook acknowledgement form on 11/27/24;</p> <p>-He/She was suspended on 2/28/25 for taking photos of resident without their consent;</p> <p>-He/She was terminated on 3/3/25</p> <p>-NA B:</p> <p>-He/She signed abuse, prevention and prohibition policy on 12/20/24;</p> <p>-He/She signed HIPPA form on 11/21/24;</p> <p>-He/She signed the employee handbook acknowledgement form on 11/21/24;</p> <p>-He/She was suspended on 2/28/25 for taking pictures and videos of resident in resident care areas without their consent;</p> <p>-He/She was terminated on 3/3/25</p> <p>-NA C:</p> <p>-He/She signed abuse, prevention and prohibition policy on 12/16/24;</p> <p>-He/She signed HIPPA form on 12/16/24;</p> <p>-He/She signed the employee handbook acknowledgement form on 12/16/24;</p> <p>-He/She was suspended on 2/28/25 for failure to follow department policies and procedures in group chat with resident pictures;</p> <p>-He/She received a written warning 3/3/25</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Maryville Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 524 North Laura Maryville, MO 64468	
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-NA D:</p> <p>-He/She signed abuse, prevention and prohibition policy on 11/12/24 and 12/19/24;</p> <p>-He/She signed HIPPA form on 11/12/24 and 12/19/24;</p> <p>-He/She signed the employee handbook acknowledgement form on 11/12/24;</p> <p>-He/She was suspended on 2/28/25 for taking pictures of resident in their room without their consent;</p> <p>-He/She was terminated on 3/3/25.</p> <p>During an interview on 3/11/25 at 11:20 A.M., Administrator said:</p> <p>-An employee reported to him/her that five nurse aides who worked at facility were involved in a Snapchat group and some of the employees had been posting resident pictures to the group;</p> <p>-He/She suspended five employees who were members of this group when he/she learned of an allegation of employees posting resident photos to Snapchat;</p> <p>-He/She completed an investigation and reported to the state agency;</p> <p>-As a result of his/her investigation he/she terminated employment with three of the five employees investigated;</p> <p>-He/She completed education with staff via an in-service and sent a message out through the employee text communication system regarding social media and cell phone use;</p> <p>-He/She had social services attempt to do trauma assessments with all residents but due to cognition status of the four residents involved they were unsuccessful in completing the assessments;</p> <p>-He/She notified all of the residents families immediately about the photos of residents that had been posted to social media.</p> <p>During an interview on 3/11/25 at 3:38 P.M., CNA A said:</p> <p>-He/She did not remember when the Snapchat group was created;</p> <p>-A Snapchat group titled work chat was initially created so employees could communicate to cover each other's shifts;</p> <p>-He/She received the first resident picture sometime in February, but was not sure of exact date;</p> <p>-Everyone in the Snapchat group was employed at the facility;</p> <p>-The group included him/her, NA A, NA B, NA C, and NA D;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The staff members who sent pictures of residents in the group was NA A, NA B, and NA D;</p> <p>-The staff member who sent a video in the Snapchat group was NA B;</p> <p>-Those staff members were terminated following the facility investigation;</p> <p>-He/She notified group members it was against HIPPA and confidentiality and residents rights to send pictures in the group;</p> <p>-He/She notified the Administrator of the Snapchat group;</p> <p>-He/She sent images from the group to the administrator;</p> <p>-The afternoon of when she reported it to the administrator the charge nurses and Certified medication technician spoke to staff on duty and told everyone working they were not to have phones out around residents and no photos or videos were to be taken;</p> <p>-That afternoon all the members of the Snapchat group left the group;</p> <p>-He/She received training on abuse and neglect, HIPPA, and no use of phones, camera's, or videos when he/she was hired by the facility;</p> <p>-After reporting he/she received a message from administration in the all staff texting application that reminded staff that no videos or phones were allowed and that the facility was residents home;</p> <p>-He/She was suspended on Friday the 28th along with NA A, NA B, NA C, and NA D;</p> <p>-He/She was suspended for two hours while the investigation occurred;</p> <p>-Only one of the four residents photographed was cognitively aware;</p> <p>-He/She did not believe any of the residents photographed would have consented to have their picture taken;</p> <p>-Administrator had provided a training on abuse and Neglect policy and HIPPA.</p> <p>During an interview on 3/11/25 at 3:53 P.M., NA C said:</p> <p>-He/She became member of Snapchat group after began employment and the group members included him/her, NA A, NA B, NA D, and CNA A;</p> <p>-Pictures began being shared within the group in February;</p> <p>-The photos shared were not explicit but of fully clothed residents;</p> <p>-Some of the residents were actually posing for pictures;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-There was four pictures that were shared in the group including pictures of Resident #1, #2, #3, and #4;</p> <p>-He/She knew it was a violation of HIPPA;</p> <p>-He/She did not report it and he/she knew that he/she should have reported it;</p> <p>-He/She removed themselves from the Snapchat group two weeks after pictures were taken;</p> <p>-He/She never replied to picture in the group and did not send any pictures in the group chat;</p> <p>-He/She only used the Snapchat group to see if any work shifts could be covered;</p> <p>-He/She was suspended by the facility when they became aware of the pictures and Snapchat group;</p> <p>-The facility investigation resulted in three of the group members, NA A, NA B, and NA D being terminated;</p> <p>-Facility implemented training on HIPPA and social media following the report;</p> <p>-A text message was sent by facility administration in our employee chat application sharing the regulation reminder and that no pictures of residents were to be taken as it was a HIPPA violation;</p> <p>-He/She had to sign and review the abuse and neglect policy and social media policy;</p> <p>-The Administrator provided staff education and a quiz on abuse and neglect;</p> <p>-He/She received training on cell phone, social media, abuse and neglect and HIPPA when she completed his/her orientation at the facility.</p> <p>During an interview on 3/11/25 at 4:10 P.M., NA E said:</p> <p>-He/She received abuse and neglect training on Friday;</p> <p>-He/She was educated not to use social media regarding the facility or any residents;</p> <p>-He/She was educated that phone use was prohibited inside the facility with residents;</p> <p>-He/She would report abuse to charge nurse, DON, and follow the chain of command;</p> <p>-He/She had not observed any abuse in facility.</p> <p>During an interview on 3/11/25 at 4:13 P.M., NA F said:</p> <p>-He/She had received abuse and neglect training in the facility;</p> <p>-He/She would report abuse to the DON;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She received cell phone policy during orientation;</p> <p>-The policy advised no phones were used in resident rooms or nurses station and they were not to take pictures of any residents;</p> <p>-He/She had received HIPPA training and was not to talk to anyone outside of the facility about residents;</p> <p>-He/She had seen a violation of HIPPA and cell phone policy;</p> <p>-He/She observed NA B with his/her phone out at the end of February;</p> <p>-He/She reported it to his/her coworkers when he/she observed NA B with their phone out;</p> <p>-Facility administration went over HIPPA and phone use at staff in service and reminded us that phones had to stay in break room of facility;</p> <p>-He/She had not observed any abuse of residents in the facility.</p> <p>During an interview on 3/11/25 at 4:31 P.M., Licensed Practical Nurse A said:</p> <p>-He/She had not witnessed any staff taking pictures or videos of residents;</p> <p>-He/She had addressed nurse aides regarding putting their phones awhile while working with them;</p> <p>-Facility had a policy that included no cell phones out while working;</p> <p>-Facility recently had in-service on cell phone use policy, HIPPA, and abuse and neglect;</p> <p>-He/She had not witnessed any abuse in facility;</p> <p>-If He/She did observe abuse or had reported abuse to him/her he/she would ensure protection of resident and notify the DON or administrator;</p> <p>-He/She would also walk abuser out of facility.</p> <p>During an interview on 3/11/25 at 4:35 P.M., NA G said:</p> <p>-He/She heard five NA's were posting photos of residents to Snapchat, but was not a part of Snapchat group;</p> <p>-He/She was educated upon hire that all cell phones had to be kept in the back room of facility;</p> <p>-He/She had not witnessed any staff members with their phones out or taking pictures or videos of residents.</p> <p>During an interview on 3/11/25 at 4:39 P.M., DON said:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She expected staff not to be using cell phones while working, have them on their person while working, and expected phones to be left in the breakroom;</p> <p>-He/She expected that no pictures or videos were taken of residents of the facility;</p> <p>-He/She did feel residents pictures and video taken was abuse;</p> <p>-The residents who had their photos taken were unable to provide consent due to cognitive status;</p> <p>-He/She expected staff not to post to social media platforms;</p> <p>-The cell phone and social media policy was covered during orientation for all employees;</p> <p>-He/She expected staff to report any violation of abuse and neglect policy immediately;</p> <p>-The Administrator served as the abuse and neglect coordinator.</p> <p>During an interview on 3/11/25 at 4:44 P.M., Administrator said:</p> <p>-He/She expected cell phones not to be out or seen while working;</p> <p>-He/She expected staff to not post on social media platforms;</p> <p>-He/She expected residents to be free from abuse.</p> <p>MO250299</p>		