

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365481	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Altercare Newark North Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 151 Price Road Newark, OH 43055	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41271</p> <p>Based on medical record review, facility Self-Reported Incident (SRI) review, video recording review, interviews, and facility policy review, this facility failed to ensure residents were not recorded without their consent or knowledge. This affected one (Resident #300) of the four residents reviewed for respect and dignity. The facility census was 66.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #300 revealed an admitted [DATE] with a discharge date of [DATE]. Diagnoses included burns to the left and right foot, osteomyelitis of the vertebra, sacral, and sacrococcygeal region, and Parkinson's disease.</p> <p>Review of Resident #300's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating an intact cognition for daily decision-making abilities. Resident #300 was noted to experience delusions and rejection of care at times.</p> <p>Review of the facility Self-Reported Incident #252058 dated 09/19/2024 revealed that Stated tested Nursing Assistant (STNA) #20 alleges recording of Resident #300 in the facility's common area. Resident #300 was interviewed and states he didn't recall any said event occurring.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Narrative Summary of Incident included: STNA #20 called the Director of Nursing (DON) and stated she was made aware of Resident #300 being recorded. STNA #20 states Resident #300 and the staff member involved was Agency STNA #79 who was not at the facility during the time of the allegations being reported. The staffing agency was immediately contacted to suspend Agency STNA #79 pending investigation. Resident #300 was interviewed and does not recall the event occurring. Resident #300 also confirms he has no issues or concerns with caregivers. Agency STNA #79 states she did record resident and her dancing in the common area but had no ill intent behind recording. She states they were laughing and having fun. Additional staff and residents were interviewed, and no direct witnesses identified. After investigation was completed, the facility determined this allegation of verbal abuse was unsubstantiated. As a result of this investigation, the facility completed the following: As a result of the investigation the facility cannot conclude that abuse occurred. Willful intent to harm could not be verified. While Agency aide acknowledges the allegation occurred, the intention was not to harm the resident. Further, the resident did not suffer any physical harm, pain, or mental anguish. The resident does not recall any incident occurring. Out of precaution, this agency aide was placed on a Do Not Returned list.</p> <p>Review of the facility's investigation revealed an facility completed interview with Agency STNA #79 dated 09/19/2024 at 3:50 P.M. revealed, STNA stated she did record Resident #300 and stated it was an innocent playful moment with no malicious or ill intent. They were dancing in the common area. Per Agency STNA #79, they were laughing and having fun. She did not mean any harm by it. She feels as if he is one of her favorite patients and she was just kidding around and having fun. Agency STNA #79 reiterated on numerous occasions she was by herself, no other staff members or residents were involved.</p> <p>Attempted to call Agency STNA #79 on 10/22/2024 at 2:06 P.M. and again at 3:50 P.M. Phone call went directly to voice mail. A voice message was left for a return phone call but none was received.</p> <p>Interview on 10/22/2024 at 2:48 P.M. with STNA #20 revealed she is friends with someone who is friends with Agency STNA #79 and claimed that her friend showed her the video of Agency STNA #79 and Resident #300 and asked her if this was her work. When she saw Resident #300, she knew right away it was recorded at her work and that was one of her residents. STNA #20 claimed as soon as she saw the video which was on 09/19/2024 she reported it to the DON and an investigation was started. Claimed she could not confirm when the video was recorded but per her knowledge the last time this STNA worked at this facility was around 09/12/2024.</p> <p>Interview on 10/22/2024 at 3:13 P.M. with The DON revealed she received a message from STNA #20 on 09/19/2024 asking her if she was aware of a video recording of Resident #300 that was uploaded to social media by Agency STNA #79. The DON claimed she was not aware of this and an investigation was started immediately. Claimed Agency STNA #79 was suspended from the facility pending investigation and the staffing agency was notified of the incident that occurred. After completing the investigating and interviewing the Agency STNA, the staffing agency was made aware that Agency STNA #79 did record Resident #300. The DON claimed she spoke with this resident on two different occasions to check on his mental and emotional status with no negative findings. Other staff were interviewed to see if something like this had occurred on different occasions with no findings. Staff were interviewed to see if they were aware of this incident with no findings. Agency STNA #79 has not returned and is not permitted to return to this facility.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled Videotaping, Photographing, and Other Imaging of Residents, No date noted revealed It is the facility's policy that residents will be protected from invasion of privacy that might occur from the use of resident photographs, videotapes, digital images, and other visual recordings during resident care or other facility activities without the written consent of the resident.</p> <p>This deficiency was an incidental finding identified during the investigation for Complaint Number OH00158324.</p>