

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER St Mary's Alzheimer's Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1899 Garfield Rd Columbiana, OH 44408	

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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808</p> <p>Based on record review, review of a facility self-reported incident (SRI), review of a social media post, review of the facility's policies on personal cell phone use and social media, and interviews the facility failed to protect the privacy of Resident #28 during personal care. This resulted in Immediate Jeopardy on 11/27/24 when Certified Nursing Assistant (CNA) #500 made a cell phone recording of Resident #28, who was observed in the video slouched in a shower chair with her pants around her ankles and her shirt pulled up above her breasts exposing her bare body from her breasts down to just above her ankles. There was a large amount of fecal matter on the floor under Resident #28 and the video panned around the shower room to show more fecal matter in another area of the room. CNA #500 posted the video to Snapchat (a social media website) and the text overlay on the video read bruh with a loudly crying face emoji. Resident #28 had a diagnosis of Alzheimer's disease and based on the reasonable person concept, a reasonable person would have suffered serious mental/emotional harm from a video of this nature being taken and then posted on social media for an undetermined number of people to access. Based on the reasonable person concept, Resident #28 suffered humiliation through the social media post. This affected one resident (#28) of four residents reviewed for privacy/confidentiality. The facility census was 83.</p> <p>On 12/09/24 at 10:45 A.M., the facility's Administrator, Director of Nursing (DON), and Regional Quality Assurance (QA) Nurse #503 were notified Immediate Jeopardy began on 11/27/24 when CNA #500 took a video of Resident #28, a violation of the resident's right and in a manner that would demean and humiliate the resident. After taking the video, CNA #500 posted the video to social media which had the potential to be viewed by an unlimited number of people via the social media platform and/or electronic communications without the resident's knowledge and/or consent.</p> <p>The Immediate Jeopardy was removed on 12/10/24 when the facility implemented the following corrective actions:</p> <p>On 11/27/24 at 6:50 P.M., Registered Nurse (RN) #502 and Licensed Practical Nurse (LPN) #506 spoke with Certified Nursing Assistant (CNA) #500 advising her of the allegation received that she posted a video on snapchat and that they needed to see her phone. RN #502 reviewed the contents of the phone and observed the video of Resident #28. The nurses required CNA #500 to delete the video from the camera roll and the recently deleted section of her phone.</p> <p>On 11/27/24 at 6:50 P.M., RN #502 informed CNA #500 that she was suspended, and CNA #500 was escorted from the building.</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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 11/27/24, RN #502 assessed Resident #28. Resident #28's physician was notified of increased lethargy and loose stools and new orders to hold medications and monitor vital signs was obtained and family was updated. Resident #28 family was notified.</p> <p>On 11/27/24 at 7:45 P.M., the Administrator began re-education of staff in the facility regarding the social media policy, which included protecting the privacy of others, and personal cell phone use. She also interviewed staff at this time to determine if they have witnessed or were aware of any staff taking pictures or videos of residents on their phones. As of 12/05/24, there were approximately 22 as needed (PRN) staff who had not received education with a plan for staff to continue as PRN staff arrive on-site for their scheduled shifts.</p> <p>On 11/27/24, the Administrator asked CNA #500 if she had taken pictures prior or posted any videos of residents in the past. The CNA denied taking any other photos or videos of residents and no other pictures or videos involving other residents were noted on the employee's phone.</p> <p>On 11/27/24 at 9:00 P.M., the Administrator sent text messages to approximately 77 employees (all staff members for which the Administrator had cell phone numbers, out of 118 staff) in regards to the facility social media policy, which included protecting the privacy of others, and then re-educated all employees again as they came into the facility per their schedule. Many employees worked PRN or worked one to two days a month and still required education.</p> <p>On 11/28/24, RN #511 provided re-education to 33 staff who arrived for their scheduled shift on this day on the facility social media policy, which included protecting the privacy of others, and personal cell phone.</p> <p>On 11/29/24, the Administrator began to complete audits during rounds for cell phone use. The Administrator made observations of staff on the units to ensure staff did not have cell phones out, were maintaining privacy and confidentiality during hands on care, and reviewed the cell phone audit sheets, which were completed by the floor nurses twice on each shift to monitor for staff cell phone use. The audit sheets included the date, time, unit location, whether cell phone use was observed, who was observed using their cell phone (if applicable), what corrective action was taken, and the initials of the nurse completing the form.</p> <p>On 11/29/24, Medical Director #512 was notified by Regional Quality Assurance (QA) Nurse #503 of the incident involving Resident #28.</p> <p>On 12/02/24 at 12:30 P.M., a meeting was held with Regional QA Nurse #503, Clinical Director #513 and Medical Director #512 to discuss the incident, actions being taken by the facility, and how continued re-education and auditing/monitoring of staff cell phone use while on duty and privacy/confidentiality during care would continue daily at this time.</p> <p>On 12/02/24, CNA #500's employment was terminated.</p> <p>On 12/09/24, an AD HOC meeting via telephone conference with Medical Director #512, Director of Nursing (DON), the Administrator, and Regional QA Nurse #503 to notify Medical Director #512 of the State agency survey and Immediate Jeopardy situation. A discussion occurred related to on-going education of all staff, and the continuation of monitoring staff cell phone use and resident privacy/confidentiality during care.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 12/09/24, signs were posted in resident care areas which included: no cell phone usage on the floor.</p> <p>On 12/10/24 all residents with a Brief Interview for Mental Status (BIMS) score of eight or higher (Residents #8, #24, #36, #43, #54, #67, #71, #72, and #73), were interviewed by Bookkeeper #515 revealed to Privacy/Confidentiality.</p> <p>The facility implemented a plan to continue to monitor/audit for cell phone use on the unit and ensure residents privacy was maintained during care. Audits/monitoring would be completed by the DON and/or designee by observation on the units for personal cell phone use and observation of privacy being maintained during resident care three times per day for five days a week on various shifts/times for three weeks and then three times per day on various shifts/times for three times a week for three weeks. All audits would be reviewed by the Quality Assurance and Performance Improvement (QAPI) committee to determine the need for continuation of audits. In addition, the DON and/or designee would interview five staff members every week for eight weeks on various shifts and in various departments on abuse policies, definitions, reporting and understanding of the facility abuse policy and social media policy. Interviews would be reviewed by the QAPI committee to determine the need for continued education.</p> <p>Although the Immediate Jeopardy was removed on 12/10/24, the facility remained out of compliance at Severity Level 2 (no actual harm with the potential for more than minimal harm that was not Immediate Jeopardy) as the facility was in the process of implementing their corrective action and monitoring to ensure on-going compliance.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, dementia, major depressive disorder, generalized anxiety disorder, disorientation, and altered mental status. The resident passed away at the facility on 12/06/24.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/08/24, revealed Resident #28 had severe cognitive impairment, was always incontinent of urine and bowel, and was dependent on staff for toilet transfers, toileting hygiene, shower transfers, and showering self.</p> <p>Review of the care plan, revised 11/13/24, revealed Resident #28 had an activities of daily living (ADL) self-care deficit requiring maximum to total assistance to complete tasks due to confusion, dementia, difficulty sequencing, incomplete performance, cognitive loss, and functional loss. Interventions included shower one to two times per week with total assistance by one staff for showering, total assistance by two staff for toilet use, dependent on two staff to transfer between surfaces, and encourage resident participation to the fullest extent possible with each interaction.</p> <p>Review of a progress note dated 11/27/24 at 11:28 A.M. revealed Resident #28 complained of lower abdominal discomfort, the resident's abdomen was soft when palpated and non-distended, bowel sounds were active, and a medium bowel movement was reported.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of a progress note dated 11/27/24 at 5:15 P.M. revealed Resident #28 had a large loose bowel movement and was continuously moving bowels, vital signs were taken indicating an abnormal blood pressure of 80/68 (hypotensive) and blood oxygen saturation of 93%. The physician was notified and gave new orders to hold all oral medications and retake vital signs in one hour. A note dated 11/27/24 at 6:15 P.M. revealed Resident #28's vital signs were taken indicating an abnormal blood pressure of 82/52 (hypotensive). The physician was notified and gave new orders to discontinue medications and obtain a hospice consult due to end stage Alzheimer's disease.</p> <p>Review of an undated video with a time stamp in the corner of 6:40 (did not indicate whether it was A.M. or P.M.), shared to Snapchat (a social media website) by CNA #500, revealed Resident #28 was seen slouched in a shower chair with her pants around her ankles and her shirt pulled up above her breasts exposing her bare body from her breasts down to just above her ankles. There was a large amount of fecal matter on the floor under Resident #28 and the video panned around the shower room to show more fecal matter in another area of the room. The text overlay on the video reads bruh with the loudly crying face emoji.</p> <p>Review of a facility Self-Reported Incident (SRI), tracking number 254554, dated 11/27/24 and timed 7:21 P.M., revealed on 11/27/24 at 6:42 P.M. the Administrator was notified by Licensed Practical Nurse (LPN) #506 that the facility received an anonymous phone call reporting CNA #500 posted a video of a woman (identified to be Resident #28) after a shower to Snapchat (a social media platform). The Administrator instructed LPN #506 and Registered Nurse (RN) #502 to question CNA #500. Both LPN #506 and RN #502 saw the video of Resident #28 on CNA #500's phone, and CNA #500 was immediately suspended. As a result of an investigation, the facility unsubstantiated an allegation of abuse and included: The facility has determined that emotional abuse did not occur, Resident was unaware of the incident. The STNA was suspended pending outcome of investigation and terminated on 12/02/24 based on violation of facility social media policy.</p> <p>On 12/05/24 at 10:08 A.M., an observation of Resident #28 revealed the resident was laying in bed with her eyes closed, resting peacefully, and a blanket covered the resident's torso and legs. Resident #28 was not responsive at this time.</p> <p>On 12/05/24 at 10:14 A.M., an interview with Regional QA Nurse #503 confirmed a CNA (CNA #500) took a video of a resident (Resident #28) on her cell phone and then posted the video to Snapchat on the day before Thanksgiving (Wednesday, 11/27/24). Regional QA Nurse #503 said the CNA's cousin called the facility to report the video, the nurse on duty identified the video on the CNA's cell phone, the video was deleted from the CNA's cell phone, and the CNA was escorted out of the facility.</p> <p>On 12/05/24 at 11:10 A.M., an interview with Resident #28's representative revealed they received a call the evening before Thanksgiving to notify them that one of the (facility) aides took a video of Resident #28 and posted it to social media. Resident #28's representative stated they had not seen the video and they did not know whether the video was taken to make fun of someone who was dying or to be funny. Resident #28's representative said the situation was not funny and voiced they were absolutely livid about the incident.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 12/05/24 at 11:24 A.M., an interview with CNA #500 confirmed she took a video of Resident #28. The CNA claimed the video was taken out of concern to show the nurse the amount of feces the resident had. CNA #500 revealed she posted the video to a Snapchat story that was shared with four individuals. CNA #500 was unable to provide an explanation for posting the video on Snapchat and she stated the video was removed from Snapchat 15 to 20 minutes later when one of her friends told her it was inappropriate to post the video. CNA #500 confirmed she was escorted out of the facility and her employment was terminated (as a result of the incident).</p> <p>On 12/05/24 at 12:04 P.M., an interview with RN #502 revealed Resident #28 had a large loose stool that was not easy to clean, and Resident #28 was taken to the shower room to clean her up following bowel incontinence. Following the incident of the video post of Resident #28, RN #502 said she was instructed by the Administrator to talk to CNA #500 with LPN #506 to find out what happened. RN #502 said CNA #500 offered to show her phone to RN #502 and LPN #506. RN #502 said upon reviewing CNA #500's phone, there were two copies of a video of Resident #28 in CNA #500's saved Snapchat videos. RN #502 further stated Resident #28 was not wearing any pants in the video, her bottom half was completely exposed, and there was feces shown in the video. RN #502 said the videos were deleted from CNA #500's phone at that time and CNA #500 was escorted out of the facility.</p> <p>On 12/05/24 at 12:24 P.M., an interview with LPN #506 revealed Resident #28 had been ill around dinner time and RN #502 assisted with Resident #28 in the shower room. LPN #506 said she answered the facility's phone around 6:45 P.M. and was informed by an anonymous caller that CNA #500 added a post to Snapchat that showed a naked resident (identified to be Resident #28) in the facility. LPN #506 said she immediately notified the Administrator and after a few minutes, the Administrator instructed LPN #506 to question CNA #500 with RN #502. She stated at that time, a third nurse in the facility was on the phone with someone else who alleged the same incident as the first anonymous caller. LPN #506 said while she and RN #502 were questioning CNA #500 about the incident, they found the video of Resident #28 on CNA #500's phone in the album for saved Snapchat videos. LPN #506 said she watched as CNA #500 deleted the video from her cell phone. RN #502 educated CNA #500 on the Health Insurance Portability and Accountability Act (HIPAA) and explained that this incident was a HIPAA violation. LPN #506 said she escorted CNA #500 out of the building and watched until CNA #500 left the premises.</p> <p>On 12/05/24 at 12:37 P.M., an interview with LPN #505 revealed she was the third nurse who answered the phone when a second call was received. LPN #505 stated a lady called the facility to report an incident that she saw on social media (involving a resident at the facility). LPN #505 said while she was on the phone, LPN #506 approached from another hall and was already aware of the incident due to receiving the first phone call. LPN #505 said CNA #500 was the assigned shower aide for the day of the incident and she had given a lot of residents' showers. LPN #505 denied any additional involvement in the incident or the facility's internal investigation of the incident.</p> <p>On 12/05/24 at 12:55 P.M., an interview with CNA #507 revealed she was aware of a video taken of a resident who was naked, but she denied any involvement in the incident or the facility's internal investigation of the incident.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 12/05/24 at 1:42 P.M., an interview with CNA #508 revealed she was assigned to complete showers with CNA #500 on 11/27/24. CNA #508 said Resident #28 had multiple episodes of bowel incontinence and explosive diarrhea, which was cleaned up after each episode, and the resident was assessed by RN #502. While providing care, CNA #508 said Resident #28 was positioned over the toilet in the shower chair due to the frequency of her incontinence. CNA #508 said there was feces all over the floor and she began cleaning it up. CNA #508 stated while she was cleaning up the floor, she looked over at CNA #500 and noticed she was recording on her phone. CNA #508 said she asked CNA #500 why she was recording because that was a HIPAA violation and CNA #500 responded I know, but it's funny. CNA #508 said Resident #28 was cleaned up and taken back to her room, then a few minutes later the nurses came and got CNA #500 from the shower room.</p> <p>On 12/05/24 at 3:35 P.M., an interview with CNA #509 revealed on 11/27/24 she was working on Resident #28's unit with CNA #510. CNA #509 stated Resident #28 had multiple episodes of bowel incontinence after dinner that required multiple showers to clean the resident. CNA #509 stated CNA #500 was on her phone in the shower room and that was nothing new because CNA #500 was always on her phone texting people. CNA #509 said she tried to get Resident #28 dressed, but the resident was hard to position in the shower chair and she could not get Resident #28's clothes on all the way. CNA #509 stated Resident #28's shirt was not all the way down, leaving her breasts exposed, and she had no pants on. CNA #509 stated once Resident #28 was cleaned up and dressed, she was taken back to her room and put in bed by CNA #509 and CNA #510. CNA #509 said a few minutes after all that occurred, she heard RN #502 tell CNA #500 that she needed to speak with her and needed to see her cell phone. CNA #509 said she was unaware that a video was taken until RN #502 asked to see CNA #500's phone. CNA #509 further stated she did not see the video on Snapchat the day the video was taken, but stated she did see the video shared to a local Facebook page a few days after the incident occurred. CNA #509 reported the video shared to Facebook had since been removed.</p> <p>On 12/05/24 at 3:50 P.M., an interview with CNA #510 revealed on 11/27/24 Resident #28 was incontinent and had feces under her chair. CNA #510 said it was easier to clean Resident #28 up in the shower. CNA #510 said CNA #509 assisted with cleaning the floor in the hallway and CNA #508 assisted with showering Resident #28 after multiple episodes of incontinence in the shower room. CNA #510 stated CNA #500 was on her phone in the shower room but that was nothing new because CNA #500 was always on her phone texting while at work.</p> <p>Review of the facility's policy on personal telephone use, dated January 2009, indicated cell phones that were not provided by the company were not to be permitted to be ON in the building during working hours and they should not be on an employee's person.</p> <p>On 12/05/24 at 4:45 P.M., an interview with the Administrator, DON, and Regional QA Nurse #503 revealed facility staff were permitted to use their phones at the nurse's stations to contact medical practitioners and resident family members, but staff should not have their personal cell phones in resident care areas or while providing personal care.</p> <p>On 12/09/24 at 9:10 A.M., an interview with the Administrator confirmed the facility's personal phone policy indicated non-company cell phones were to be turned off during working hours and staff should not have their personal cell phones on them while at work. The Administrator further stated that was an outdated policy that needed revision because facility staff utilized their personal cell phones to communicate with practitioners and staffing agencies while working in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy on social media use, dated January 2021, indicated staff members should exercise care when participating in social media, follow the same behavioral standards online that they would while engaging in personal and professional interactions, and staff members were accountable for anything they posted to social media about the facility and its staff or residents. The definition of social media, as defined in the facility's policy, included all forms of public, web-based communication, whether existing at the time of this policy's adoption or created at a future date, including but not limited to the following: social networking sites (e.g. Facebook, LinkedIn), video and photo-sharing websites (e.g. Instagram, YouTube), micro-blogging sites (e.g. Twitter, Snapchat, TikTok), blogs (e.g. corporate blogs, personal blogs, media-hosted blogs), forums and discussion boards (e.g. Yahoo! groups, Google groups), and collaborative publishing (e.g. Wikipedia). The policy indicated the privacy of others should be protected and staff members were not permitted to post any photographs or videos of facility residents without permission from those individuals and the Administrator.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160397 and Complaint Number OH00160368.</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</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** 44808</p> <p>Based on observation, record review, review of a facility self-reported incident (SRI), review of a social media post, review of the facility's policies on personal cell phone use, social media, and abuse, and interview, the facility failed to ensure Resident #28, who was assessed to be cognitively impaired, was free from staff to resident mental/emotional abuse when Certified Nursing Assistant (CNA) #500 took a video of Resident #28 during personal care on her personal cell phone and posted the video to the social media platform Snapchat. This resulted in Immediate Jeopardy on 11/27/24 when CNA #500 made a cell phone recording of Resident #28, who was seen slouched in a shower chair with her pants around her ankles and her shirt pulled up above her breasts exposing her bare body from her breasts down to just above her ankles. There was a large amount of fecal matter on the floor under Resident #28 and the video panned around the shower room to show more fecal matter in another area of the room. The text overlay on the video read bruh with a loudly crying face emoji. Resident #28 had a diagnosis of Alzheimer's disease and based on the reasonable person concept, any reasonable person would have suffered serious mental/emotional harm from a video of this nature being taken and then posted on social media for an undetermined number of people to access. Based on the reasonable person concept, Resident #28 suffered humiliation through the social media post. In addition, the content of the video and condition of the resident portrayed an incident of neglect (the lack of timely and necessary care and services by staff to meet the resident's total care needs resulting in mental anguish/emotional distress determined by the reasonable person concept) by the facility staff responsible for providing care to Resident #28. This affected one resident (#28) of four residents reviewed for abuse. The facility census was 83.</p> <p>On 12/09/24 at 10:45 A.M., the facility's Administrator, Director of Nursing (DON), and Regional Quality Assurance (QA) Nurse #503 were notified Immediate Jeopardy began on 11/27/24 when CNA #500 took a video of Resident #28 in a manner that would demean and humiliate the resident constituting a situation of abuse and then CNA #500 posted the video to social media which had the potential to be viewed by an unlimited number of people via the social media platform and/or electronic communications without the resident's knowledge and/or consent.</p> <p>The Immediate Jeopardy was removed on 12/10/24 when the facility implemented the following corrective actions:</p> <p>On 11/27/24 at 6:50 P.M., Registered Nurse (RN) #502 and Licensed Practical Nurse (LPN) #506 spoke with Certified Nursing Assistant (CNA) #500 advising her of the allegation received that she posted something on snapchat and that they need to see her phone. RN #502 reviewed the contents of the phone and observed the video of the resident. The nurses made CNA #500 delete the video from the camera roll and the recently deleted section of her phone.</p> <p>On 11/27/24 at 6:50 P.M., RN #502 informed CNA #500 that she was suspended, and CNA #500 was escorted from the building.</p> <p>On 11/27/24, RN #502 assessed Resident #28. Resident #28's physician was notified of increased lethargy and loose stools and new orders to hold medications and monitor vital signs was obtained and family was updated. Resident #28's family was notified.</p> <p>(continued on next page)</p>		

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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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 11/27/24 at 7:45 P.M., the Administrator began re-education of staff in the facility regarding the social media policy, which included protecting the privacy of others, and personal cell phone use. She also interviewed staff at this time to determine if they had witnessed or were aware of any staff taking pictures or videos of residents on their phones. As of 12/05/24, there were approximately 22 as needed (PRN) staff who had not received education. Education remained ongoing at this time for PRN staff as they arrive on-site for their scheduled shifts.</p> <p>On 11/27/24, the Administrator asked CNA #500 if she had taken pictures prior or posted any videos of residents in the past and she denied stating this was her first time. No other pictures or videos involving other residents were noted on the phone.</p> <p>On 11/27/24 at 9:00 P.M., the Administrator sent text messages to approximately 77 employees (all staff members for which the Administrator had cell phone numbers, out of 118 staff) in regards to social media policy, which included protecting the privacy of others, and then re-educated all employees again as they came into the facility per their schedule as many employees were PRN or work one to two days a month.</p> <p>On 11/28/24 RN #511 provided re-education to 33 staff who arrived for their scheduled shift on the social media policy, which included protecting the privacy of others, and personal cell phone use.</p> <p>On 11/29/24, the Administrator began to complete audits during rounds for cell phone use. The Administrator made observations of staff on the units to ensure staff did not have cell phones out, were maintaining privacy and confidentiality during hands on care, and reviewed the cell phone audit sheets, which were completed by the floor nurses twice on each shift to monitor for staff cell phone use. The audit sheets included the date, time, unit location, whether cell phone use was observed, who was observed using their cell phone (if applicable), what corrective action was taken, and the initials of the nurse completing the form.</p> <p>On 11/29/24, Medical Director #512 was notified by Regional QA Nurse #503 of the incident involving Resident #28.</p> <p>On 12/02/24 at 12:30 P.M. a meeting was held with Regional QA Nurse #503, Clinical Director #513 and Medical Director #512 to discuss the incident, actions being taken by the facility, and how continued re-education and auditing/monitoring of staff cell phone use while on duty and privacy/confidentiality during care would continue daily at this time.</p> <p>On 12/02/24, CNA #500's employment was terminated.</p> <p>On 12/09/24, an AD HOC meeting via telephone conference with Medical Director #512, Director of Nursing (DON), the Administrator, and Regional QA Nurse #503 to notify Medical Director #512 of the State agency Immediate Jeopardy. A discussion was held regarding education of all staff, and the continuation of monitoring staff cell phone use and resident privacy/confidentiality during care.</p> <p>On 12/09/24, signs were posted in resident care areas that stated: no cell phone usage on the floor.</p> <p>On 12/09/24 and 12/10/24 staff re-education was provided on the facility abuse policy and the relation to the social media policy in-person or via phone conversation by facility department heads.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 12/10/24 all residents with a Brief Interview for Mental Status (BIMS) score of eight or higher, (Residents #8, #24, #36, #43, #54, #67, #71, #72, and #73) were interviewed by Bookkeeper #515 related to Privacy/Confidentiality.</p> <p>On 12/10/24 Corporate QA Director #514 re-educated the Administrator on the facility abuse policy and the reasonable person concept. The reasonable person concept would be utilized for future investigations. At this time, the DON was also knowledgeable of the reasonable person concept and verbalized understanding of reporting requirements to the State agency. The facility implemented a plan for Corporate QA office staff to monitor abuse allegations on an on-going basis.</p> <p>On 12/10/24, Regional QA Nurse #503 added an addendum to the facility SRI to reflect the incident/allegation was substantiated.</p> <p>The facility implemented a plan to monitor/audit for cell phone use on the unit and ensure all residents privacy was maintained during care. Audits/monitoring would be completed by the DON and/or designee by observation on the units for personal cell phone use and observation of privacy being maintained during resident care three times per day for five days a week on various shifts/times for three weeks and then three times per day on various shifts/times for three times a week for three weeks. All audits would be reviewed by the Quality Assurance and Performance Improvement (QAPI) committee to determine the need for continuation of audits. In addition, the DON and/or designee would interview five staff members every week for eight weeks on various shifts and in various departments on abuse policies, definitions, reporting and understanding of the facility abuse policy and social media policy. Interviews would be reviewed by the QAPI committee to determine the need for continued education.</p> <p>Although the Immediate Jeopardy was removed on 12/10/24, the facility remained out of compliance at Severity Level 2 (no actual harm with the potential for more than minimal harm that was not Immediate Jeopardy) as the facility was in the process of implementing their corrective action and monitoring to ensure on-going compliance.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, dementia, major depressive disorder, generalized anxiety disorder, disorientation, and altered mental status. Resident #28 passed away at the facility on 12/06/24.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/08/24, revealed Resident #28 had severe cognitive impairment, was always incontinent of urine and bowel, and was dependent on staff for toilet transfers, toileting hygiene, shower transfers, and showering self.</p> <p>Review of the care plan, revised 11/13/24, revealed Resident #28 had an activities of daily living (ADL) self-care deficit requiring maximum to total assistance to complete tasks due to confusion, dementia, difficulty sequencing, incomplete performance, cognitive loss, and functional loss. Interventions included shower one to two times per week with total assistance by one staff for showering, total assistance by two staff for toilet use, dependent on two staff to transfer between surfaces, and encourage resident participation to the fullest extent possible with each interaction.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of a progress note dated 11/27/24 at 11:28 A.M. revealed Resident #28 complained of lower abdominal discomfort, the resident's abdomen was soft when palpated and non-distended, bowel sounds were active, and a medium bowel movement was reported.</p> <p>Review of a progress note dated 11/27/24 at 5:15 P.M. revealed Resident #28 had a large loose bowel movement and was continuously moving bowels, vital signs were taken indicating an abnormal blood pressure of 80/68 (hypotensive) and blood oxygen saturation of 93%. The physician was notified and gave new orders to hold all oral medications and retake vital signs in one hour. A note dated 11/27/24 at 6:15 P.M. revealed Resident #28's vital signs were taken indicating an abnormal blood pressure of 82/52 (hypotensive). The physician was notified and gave new orders to discontinue medications and obtain a hospice consult due to end stage Alzheimer's disease.</p> <p>Review of an undated video with a time stamp in the corner of 6:40 (did not indicate whether it was A.M. or P.M.), shared to Snapchat (a social media website) by CNA #500, revealed Resident #28 was seen slouched in a shower chair with her pants around her ankles and her shirt pulled up above her breasts exposing her bare body from her breasts down to just above her ankles. There was a large amount of fecal matter on the floor under Resident #28 and the video panned around the shower room to show more fecal matter in another area of the room. The text overlay on the video reads bruh with the loudly crying face emoji.</p> <p>Review of a facility Self-Reported Incident (SRI), tracking number 254554, dated 11/27/24 and timed 7:21 P.M., revealed on 11/27/24 at 6:42 P.M. the Administrator was notified by Licensed Practical Nurse (LPN) #506 that the facility received an anonymous phone call reporting CNA #500 posted a video of a woman (identified to be Resident #28) after a shower to Snapchat (a social media platform). The Administrator instructed LPN #506 and Registered Nurse (RN) #502 to question CNA #500. Both LPN #506 and RN #502 saw the video of Resident #28 on CNA #500's phone, and CNA #500 was immediately suspended. As a result of an investigation, the facility unsubstantiated an allegation of abuse and included: The facility has determined that emotional abuse did not occur, Resident was unaware of the incident. The STNA was suspended pending outcome of investigation and terminated on 12/02/24 based on violation of facility social media policy.</p> <p>On 12/05/24 at 10:08 A.M., an observation of Resident #28 revealed the resident was laying in bed with her eyes closed, resting peacefully, and a blanket covered the resident's torso and legs. Resident #28 was not responsive at this time.</p> <p>On 12/05/24 at 10:14 A.M., an interview with Regional QA Nurse #503 confirmed a CNA (CNA #500) took a video of a resident (Resident #28) on their cell phone and then posted the video to Snapchat on the day before Thanksgiving (Wednesday, 11/27/24). Regional QA Nurse #503 said the CNA's cousin called the facility to report the video, the nurse on duty identified the video on the CNA's cell phone, the video was deleted from the CNA's cell phone, and the CNA was escorted out of the facility.</p> <p>On 12/05/24 at 11:10 A.M., an interview with Resident #28's representative revealed they received a call the evening before Thanksgiving to notify them that one of the (facility) aides took a video of Resident #28 and posted it to social media. Resident #28's representative stated they had not seen the video and they did not know whether the video was taken to make fun of someone who was dying or to be funny. Resident #28's representative said the situation was not funny and voiced they were absolutely livid about the incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 12/05/24 at 11:24 A.M., an interview with CNA #500 confirmed she took a video of Resident #28. The CNA claimed the video was taken out of concern to show the nurse the amount of feces the resident had. CNA #500 revealed she posted the video to a Snapchat story that was shared with four individuals. CNA #500 was unable to provide an explanation for posting the video on Snapchat and she stated the video was removed from Snapchat 15 to 20 minutes later when one of her friends told her it was inappropriate to post the video. CNA #500 confirmed she was escorted out of the facility and her employment was terminated (as a result of the incident).</p> <p>On 12/05/24 at 12:04 P.M., an interview with RN #502 revealed on 11/27/24 Resident #28 had a large loose stool that was not easy to clean, and Resident #28 was taken to the shower room to clean her up following bowel incontinence. RN #502 stated CNA #500 refused to shower Resident #28 because she stated she had given Resident #28 a shower the previous day. RN #502 said CNA #509 and CNA #510 agreed to shower Resident #28 and began preparing Resident #28 for a shower at that time. RN #502 stated Resident #28 had been assessed earlier in the day due to unresponsiveness and Resident #28's family was considering hospice at that time and did not want Resident #28 sent to the hospital. Following the incident of the video post of Resident #28, RN #502 said she was instructed by the Administrator to talk to CNA #500 with LPN #506 to find out what happened. RN #502 said CNA #500 offered to show her phone to RN #502 and LPN #506. RN #502 said upon reviewing CNA #500's phone, there were two copies of a video of Resident #28 in CNA #500's saved Snapchat videos. RN #502 further stated Resident #28 was not wearing any pants in the video, her bottom half was completely exposed, and there was feces shown in the video. RN #502 said the videos were deleted from CNA #500's phone at that time and CNA #500 was escorted out of the facility.</p> <p>On 12/05/24 at 12:24 P.M., an interview with LPN #506 revealed on 11/27/24 Resident #28 had been ill around dinner time and RN #502 assisted with Resident #28 in the shower room. LPN #506 said she answered the facility's phone around 6:45 P.M. and was informed by an anonymous caller that CNA #500 added a post to Snapchat that showed a naked resident (identified to be Resident #28) in the facility. LPN #506 said she immediately notified the Administrator and after a few minutes, the Administrator instructed LPN #506 to question CNA #500 with RN #502. She stated at that time, a third nurse in the facility was on the phone with someone else who alleged the same incident as the first anonymous caller. LPN #506 said while she and RN #502 were questioning CNA #500 about the incident, they found the video of Resident #28 on CNA #500's phone in the album for saved Snapchat videos. LPN #506 said she watched as CNA #500 deleted the video from her cell phone. RN #502 educated CNA #500 on the Health Insurance Portability and Accountability Act (HIPAA) and explained that this incident was a HIPAA violation. LPN #506 said she escorted CNA #500 out of the building and watched until CNA #500 left the premises.</p> <p>On 12/05/24 at 12:37 P.M., an interview with LPN #505 revealed she was the third nurse who answered the phone when a second call was received. LPN #505 stated a lady called the facility to report an incident that she saw on social media (involving a resident at the facility). LPN #505 said while she was on the phone, LPN #506 approached from another hall and was already aware of the incident due to receiving the first phone call. LPN #505 said CNA #500 was the assigned shower aide for the day of the incident and she had given a lot of resident's showers. LPN #505 denied any additional involvement in the incident or the facility's internal investigation of the incident.</p> <p>On 12/05/24 at 12:55 P.M., an interview with CNA #507 revealed she was aware of a video taken of a resident who was naked, but she denied any involvement in the incident or the facility's internal investigation of the incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 12/05/24 at 1:42 P.M., an interview with CNA #508 revealed on 11/27/24 she was assigned to complete showers with CNA #500 on 11/27/24. She said CNA #509 and CNA #510 brought Resident #28 to the shower room to clean her up after incontinence and CNA #500 refused the shower because Resident #28 was showered the prior day. CNA #508 said she offered to assist CNA #509 and CNA #510 with the shower as soon as she finished assisting another resident. CNA #508 stated there was a large amount of liquid feces when they removed Resident #28's clothing. CNA #508 stated that she, along with CNA #509 and CNA #510, assisted Resident #28 in getting cleaned up and then Resident #28 was incontinent again, which required her to be cleaned up again. CNA #508 said Resident #28 had explosive diarrhea, was cleaned up again, and was assessed by RN #502. CNA #508 said Resident #28 was positioned over the toilet in the shower chair due to the frequency of her incontinence. CNA #508 said there was feces all over the floor and she began cleaning it up. CNA #508 stated while she was cleaning up the floor, she looked over at CNA #500 and noticed she was recording on her phone. CNA #508 said she asked CNA #500 why she was recording because that was a HIPAA violation and CNA #500 responded I know, but it's funny. CNA #508 said Resident #28 was cleaned up and taken back to her room, then a few minutes later the nurses came and got CNA #500 from the shower room.</p> <p>On 12/05/24 at 3:35 P.M., an interview with CNA #509 revealed on 11/27/24 she was working on Resident #28's unit with CNA #510. CNA #509 stated Resident #28 had an episode of incontinence after dinner that required a shower to clean the resident. CNA #509 said Resident #28 was taken to the shower room, where CNA #500 refused to complete the shower because Resident #28 had been showered the day before. CNA #509 said she was in and out of the shower room cleaning up the hallway from where they transported Resident #28 to the shower room. CNA #509 said CNA #500, CNA #508, and CNA #510 were in the shower room with Resident #28. CNA #509 stated CNA #500 was on her phone in the shower room and that was nothing new because CNA #500 was always on her phone texting people. CNA #509 said Resident #28 kept having diarrhea and had to be showered again. CNA #509 said she tried to get Resident #28 dressed, but the resident was hard to position in the shower chair and she could not get Resident #28's clothes on all the way. CNA #509 stated Resident #28's shirt was not all the way down, leaving her breasts exposed, and she had no pants on. CNA #509 stated once Resident #28 was cleaned up and dressed, she was taken back to her room and put in bed by CNA #509 and CNA #510. CNA #509 said CNA #500 and CNA #508 continued giving showers. CNA #509 said a few minutes after all that occurred, she heard RN #502 tell CNA #500 that she needed to speak with her and needed to see her cell phone. CNA #509 said she was unaware that a video was taken until RN #502 asked to see CNA #500's phone. CNA #509 further stated she did not see the video on Snapchat the day the video was taken, but stated she did see the video shared to a local Facebook page a few days after the incident occurred. CNA #509 reported the video shared to Facebook had since been removed.</p> <p>On 12/05/24 at 3:50 P.M., an interview with CNA #510 revealed on 11/27/24 Resident #28 was incontinent and had feces under her chair. CNA #510 said it was easier to clean Resident #28 up in the shower. CNA #510 said CNA #509 assisted with cleaning the floor in the hallway and CNA #508 assisted with showering Resident #28 after multiple episodes of incontinence in the shower room. CNA #510 stated CNA #500 was on her phone in the shower room and that was nothing new because CNA #500 was always on her phone texting while at work.</p> <p>Review of the facility's policy on personal telephone use, dated January 2009, indicated cell phones that were not provided by the company were not to be permitted to be ON in the building during working hours and they should not be on an employee's person.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 12/05/24 at 4:45 P.M., an interview with the Administrator, DON, and Regional QA Nurse #503 revealed facility staff were permitted to use their phones at the nurse's stations to contact medical practitioners and resident family members, but staff should not have their personal cell phones in resident care areas or while providing personal care.</p> <p>On 12/09/24 at 9:10 A.M., an interview with the Administrator confirmed the facility's personal phone policy indicated non-company cell phones were to be turned off during working hours and staff should not have their personal cell phones on them while at work. The Administrator further stated that was an outdated policy that needed revision because facility staff utilized their personal cell phones to communicate with practitioners and staffing agencies while working in the facility.</p> <p>Review of the facility's policy on social media use, dated January 2021, indicated staff members should exercise care when participating in social media, follow the same behavioral standards online that they would while engaging in personal and professional interactions, and staff members were accountable for anything they posted to social media about the facility and its staff or residents. The definition of social media, as defined in the facility's policy, included all forms of public, web-based communication, whether existing at the time of this policy's adoption or created at a future date, including but not limited to the following: social networking sites (e.g. Facebook, LinkedIn), video and photo-sharing websites (e.g. Instagram, YouTube), micro-blogging sites (e.g. Twitter, Snapchat, TikTok), blogs (e.g. corporate blogs, personal blogs, media-hosted blogs), forums and discussion boards (e.g. Yahoo! groups, Google groups), and collaborative publishing (e.g. Wikipedia). The policy indicated staff members were responsible for anything they posted online, must be respectful to the facility and its staff and residents, ensure communications or postings do not violate any of the facility's policies including HIPAA, must not express pornographic or indecent content, never post anything to a social media site or on the internet that interferes with resident obligations, and remember everything written online can be traced back to its author. Violations of this policy would result in discipline up to and including discharge.</p> <p>Review of the facility's policy on abuse prevention, dated 03/2023, indicated the facility would protect all residents from verbal, mental, physical, emotional, or financial abuse by staff, families, residents, visitors or outside ancillary service employees or in any situation that would be harmful to the resident. The definition of mental abuse, as defined in the facility's policy, included nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate a resident. The definition of neglect, as defined in the facility's policy, included failures of the facility, its employees or service providers to provide a resident with goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160397 and Complaint Number OH00160368.</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808</p> <p>Based on observation, record review, review of a facility self-reported incident (SRI), review of a social media post, review of the facility's policies on personal cell phone use, social media, and abuse, and interview, the facility failed to effectively implement their abuse policy to prevent staff to resident abuse and to appropriately recognize the incident as abuse. This resulted in Immediate Jeopardy on 11/27/24 when Certified Nursing Assistant (CNA) #500 took a video of Resident #28 during personal care, in which the resident's bare body was from her breasts down to just above the ankles with a substantial amount of fecal matter on the floor around the resident, on her personal cell phone and posted the video to the social media platform Snapchat with a text overlay that read bruh with a loudly crying face emoji. While the facility did report the incident to the State agency, the facility concluded the incident of abuse was unsubstantiated based on the resident being unaware of the incident. Resident #28 had a diagnosis of Alzheimer's disease and based on the reasonable person concept, any reasonable person would have suffered serious mental/emotional harm from a video of this nature being taken and then posted on social media for an undetermined number of people to access. Based on the reasonable person concept, Resident #28 suffered humiliation through the social media post. This affected one resident (#28) of four residents reviewed for abuse. The facility census was 83.</p> <p>On 12/09/24 at 10:45 A.M., the facility's Administrator, Director of Nursing (DON), and Regional Quality Assurance (QA) Nurse #503 were notified Immediate Jeopardy began on 11/27/24 when CNA #500 took a video of Resident #28 in a manner that would demean and humiliate the resident constituting a situation of abuse, then CNA #500 posted the video to social media which had the potential to be viewed by an unlimited number of people via the social media platform and/or electronic communications without the resident's knowledge and/or consent. In addition, the facility failed to recognize this incident as a situation of abuse when their investigation concluded the allegation of abuse was unsubstantiated.</p> <p>The Immediate Jeopardy was removed on 12/10/24 when the facility implemented the following corrective actions:</p> <p>On 11/27 /24 at 6:50 P.M., Registered Nurse (RN) #502 and Licensed Practical Nurse (LPN) #506 spoke with Certified Nursing Assistant (CNA) #500 advising her of the allegation received that she posted something on snapchat and that they need to see her phone. RN #502 reviewed the contents of the phone and observed the video of Resident #28. The nurses made CNA #500 delete the video from the camera roll and the recently deleted section of her phone.</p> <p>On 11/27/24 at 6:50 P.M., RN #502 informed CNA #500 she was suspended, and CNA #500 was escorted from the building.</p> <p>On 11/27/24, RN #502 assessed Resident #28. Resident #28's physician was notified of increased lethargy and loose stools and new orders to hold medications and monitor vital signs was obtained and family was updated. Resident #28's family was notified.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 11/27/24 at 7:45 P.M., the Administrator began re-education of staff in the facility regarding the social media policy, which included protecting the privacy of others, and personal cell phone use. She also interviewed staff at this time to determine if they have witnessed or were aware of any staff taking pictures or videos of residents on their phones. As of 12/05/24, there were approximately 22 as needed (PRN) staff who had not received education with education on-going as PRN staff arrived on-site for their scheduled shifts.</p> <p>On 11/27/24, the Administrator asked CNA #500 if she had taken pictures prior or posted any videos of residents in the past. The CNA denied taking other pictures or posting videos of other residents. No other pictures or videos involving other residents were noted on the phone.</p> <p>On 11/27/24 at 9:00 P.M., the Administrator sent text messages to approximately 77 employees (all staff members for which the Administrator had cell phone numbers, out of 118 staff) in regards to social media policy, which included protecting the privacy of others, and then re-educated all employees again as they came into the facility per their schedule. PRN staff and staff who worked one to two days a month would be educated as they arrived to work.</p> <p>On 11/28/24 RN #511 provided re-education to 33 staff who arrived for their scheduled shift related to the facility social media policy, which included protecting the privacy of others, and personal cell phone use.</p> <p>On 11/29/24, the Administrator began to complete audits during rounds for cell phone use. The Administrator made observations of staff on the units to ensure staff did not have cell phones out, were maintaining privacy and confidentiality during hands on care, and reviewed the cell phone audit sheets, which were completed by the floor nurses twice on each shift to monitor for staff cell phone use. The audit sheets included the date, time, unit location, whether cell phone use was observed, who was observed using their cell phone (if applicable), what corrective action was taken, and the initials of the nurse completing the form.</p> <p>On 11/29/24, Medical Director #512 was notified by Regional QA Nurse #503 of the incident involving Resident #28.</p> <p>On 12/02/24 at 12:30 P.M. a meeting was held with Regional QA Nurse #503, Clinical Director #513 and Medical Director #512 to discuss the incident, actions being taken by the facility, and how continued re-education and auditing/monitoring of staff cell phone use while on duty and privacy/confidentiality during care would continue daily at this time.</p> <p>On 12/02/24, CNA #500's employment was terminated.</p> <p>On 12/09/24, an AD HOC meeting via telephone conference with Medical Director #512, Director of Nursing (DON), the Administrator, and Regional QA Nurse #503 was held to notify Medical Director #512 of the State agency Immediate Jeopardy. A discussion was held regarding on-going education of all staff, and the continuation of monitoring staff cell phone use and resident privacy/confidentiality during care.</p> <p>On 12/09/24, signs were posted in resident care areas which stated: no cell phone usage on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 12/09/24 and 12/10/24 re-education on the facility abuse policy and the relation to the social media policy was completed with all staff in-person or via phone conversation by facility department heads.</p> <p>On 12/10/24 all residents with a Brief Interview for Mental Status (BIMS) score of eight or higher, Residents #8, #24, #36, #43, #54, #67, #71, #72, and #73, were interviewed by Bookkeeper #515 related to Privacy/Confidentiality.</p> <p>On 12/10/24 Corporate QA #514 re-educated the Administrator on the facility abuse policy and reasonable person concept. The reasonable person concept would be utilized for future investigations. The DON was also knowledgeable of the reasonable person concept and verbalized understanding if she was required to report an SRI. The facility implemented a plan for Corporate QA office staff to monitor abuse allegations on an on-going basis.</p> <p>On 12/10/24 Regional QA Nurse #503 completed an addendum for the facility SRI involving the incident with Resident #28 on 11/27/24. The addendum noted the allegation of abuse was substantiated.</p> <p>The facility implemented a plan to monitor/audit for cell phone use on the unit and ensure residents privacy was maintained during care. Audits/monitoring would be completed by the DON and/or designee by observation on the units for personal cell phone use and observation of privacy being maintained during resident care three times per day for five days a week on various shifts/times for three weeks and then three times per day on various shifts/times for three times a week for three weeks. All audits would be reviewed by the Quality Assurance and Performance Improvement (QAPI) committee to determine the need for continuation of audits. In addition, the DON and/or designee would interview five staff members every week for eight weeks on various shifts and in various departments on abuse policies, definitions, reporting and understanding of the facility abuse policy and social media policy. Interviews would be reviewed by the QAPI committee to determine the need for continued education.</p> <p>Although the Immediate Jeopardy was removed on 12/10/24, the facility remained out of compliance at Severity Level 2 (no actual harm with the potential for more than minimal harm that was not Immediate Jeopardy) as the facility was in the process of implementing their corrective action and monitoring to ensure on-going compliance.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, dementia, major depressive disorder, generalized anxiety disorder, disorientation, and altered mental status. The resident passed away at the facility on 12/06/24.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/08/24, revealed Resident #28 had severe cognitive impairment, was always incontinent of urine and bowel, and was dependent on staff for toilet transfers, toileting hygiene, shower transfers, and showering self.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the care plan, revised 11/13/24, revealed Resident #28 had an activities of daily living (ADL) self-care deficit requiring maximum to total assistance to complete tasks due to confusion, dementia, difficulty sequencing, incomplete performance, cognitive loss, and functional loss. Interventions included shower one to two times per week with total assistance by one staff for showering, total assistance by two staff for toilet use, dependent on two staff to transfer between surfaces, and encourage resident participation to the fullest extent possible with each interaction.</p> <p>Review of a progress note dated 11/27/24 at 11:28 A.M. revealed Resident #28 complained of lower abdominal discomfort, the resident's abdomen was soft when palpated and non-distended, bowel sounds were active, and a medium bowel movement was reported.</p> <p>Review of a progress note dated 11/27/24 at 5:15 P.M. revealed Resident #28 had a large loose bowel movement and was continuously moving bowels, vital signs were taken indicating an abnormal blood pressure of 80/68 (hypotensive) and blood oxygen saturation of 93%. The physician was notified and gave new orders to hold all oral medications and retake vital signs in one hour. A note dated 11/27/24 at 6:15 P.M. revealed Resident #28's vital signs were taken indicating an abnormal blood pressure of 82/52 (hypotensive). The physician was notified and gave new orders to discontinue medications and obtain a hospice consult due to end stage Alzheimer's disease.</p> <p>Review of an undated video with a time stamp in the corner of 6:40 (did not indicate whether it was A.M. or P. M.), shared to Snapchat (a social media website) by CNA #500, revealed Resident #28 was seen slouched in a shower chair with her pants around her ankles and her shirt pulled up above her breasts exposing her bare body from her breasts down to just above her ankles. There was a large amount of fecal matter on the floor under Resident #28 and the video panned around the shower room to show more fecal matter in another area of the room. The text overlay on the video reads bruh with the loudly crying face emoji.</p> <p>Review of a facility Self-Reported Incident (SRI), tracking number 254554, dated 11/27/24 and timed 7:21 P. M., revealed on 11/27/24 at 6:42 P.M. the Administrator was notified by Licensed Practical Nurse (LPN) #506 that the facility received an anonymous phone call reporting CNA #500 posted a video of a woman (identified to be Resident #28) after a shower to Snapchat (a social media platform). The Administrator instructed LPN #506 and Registered Nurse (RN) #502 to question CNA #500. Both LPN #506 and RN #502 saw the video of Resident #28 on CNA #500's phone, and CNA #500 was immediately suspended. As a result of an investigation, the facility unsubstantiated an allegation of abuse and included: The facility has determined that emotional abuse did not occur, Resident was unaware of the incident. The STNA was suspended pending outcome of investigation and terminated on 12/02/24 based on violation of facility social media policy.</p> <p>On 12/05/24 at 10:08 A.M., an observation of Resident #28 revealed the resident was laying in bed with her eyes closed, resting peacefully, and a blanket covered the resident's torso and legs. Resident #28 was not responsive at this time.</p> <p>On 12/05/24 at 10:14 A.M., an interview with Regional QA Nurse #503 confirmed a CNA (CNA #500) took a video of a resident (Resident #28) on her cell phone and then posted the video to Snapchat on the day before Thanksgiving (Wednesday, 11/27/24). Regional QA Nurse #503 said the CNA's cousin called the facility to report the video, the nurse on duty identified the video on the CNA's cell phone, the video was deleted from the CNA's cell phone, and the CNA was escorted out of the facility.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 12/05/24 at 11:10 A.M., an interview with Resident #28's representative revealed they received a call the evening before Thanksgiving to notify them that one of the (facility) aides took a video of Resident #28 and posted it to social media. Resident #28's representative stated they had not seen the video and they did not know whether the video was taken to make fun of someone who was dying or to be funny. Resident #28's representative said the situation was not funny and voiced they were absolutely livid about the incident.</p> <p>On 12/05/24 at 11:24 A.M., an interview with CNA #500 confirmed she took a video of Resident #28. The CNA claimed the video was taken out of concern to show the nurse the amount of feces the resident had. CNA #500 revealed she posted the video to a Snapchat story that was shared with four individuals. CNA #500 was unable to provide an explanation for posting the video on Snapchat and she stated the video was removed from Snapchat 15 to 20 minutes later when one of her friends told her it was inappropriate to post the video. CNA #500 confirmed she was escorted out of the facility and her employment was terminated (as a result of the incident).</p> <p>On 12/05/24 at 12:04 P.M., an interview with RN #502 revealed on 11/27/24 Resident #28 had a large loose stool that was not easy to clean, and Resident #28 was taken to the shower room to clean her up following bowel incontinence. RN #502 stated CNA #500 refused to shower Resident #28 because she stated she had given Resident #28 a shower the previous day. RN #502 said CNA #509 and CNA #510 agreed to shower Resident #28 and began preparing Resident #28 for a shower at that time. RN #502 stated Resident #28 had been assessed earlier in the day due to unresponsiveness and Resident #28's family was considering hospice at that time and did not want Resident #28 sent to the hospital. Following the incident of the video post of Resident #28, RN #502 said she was instructed by the Administrator to talk to CNA #500 with LPN #506 to find out what happened. RN #502 said CNA #500 offered to show her phone to RN #502 and LPN #506. RN #502 said upon reviewing CNA #500's phone, there were two copies of a video of Resident #28 in CNA #500's saved Snapchat videos. RN #502 further stated Resident #28 was not wearing any pants in the video, her bottom half was completely exposed, and there was feces shown in the video. RN #502 said the videos were deleted from CNA #500's phone at that time and CNA #500 was escorted out of the facility.</p> <p>On 12/05/24 at 12:24 P.M., an interview with LPN #506 revealed on 11/27/24 Resident #28 had been ill around dinner time and RN #502 assisted with Resident #28 in the shower room. LPN #506 said she answered the facility's phone around 6:45 P.M. and was informed by an anonymous caller that CNA #500 added a post to Snapchat that showed a naked resident (identified to be Resident #28) in the facility. LPN #506 said she immediately notified the Administrator and after a few minutes, the Administrator instructed LPN #506 to question CNA #500 with RN #502. She stated at that time, a third nurse in the facility was on the phone with someone else who alleged the same incident as the first anonymous caller. LPN #506 said while she and RN #502 were questioning CNA #500 about the incident, they found the video of Resident #28 on CNA #500's phone in the album for saved Snapchat videos. LPN #506 said she watched as CNA #500 deleted the video from her cell phone. RN #502 educated CNA #500 on the Health Insurance Portability and Accountability Act (HIPAA) and explained that this incident was a HIPAA violation. LPN #506 said she escorted CNA #500 out of the building and watched until CNA #500 left the premises.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 12/05/24 at 12:37 P.M., an interview with LPN #505 revealed on 11/27/24 she was the third nurse who answered the phone when a second call was received. LPN #505 stated a lady called the facility to report an incident that she saw on social media (involving a resident at the facility). LPN #505 said while she was on the phone, LPN #506 approached from another hall and was already aware of the incident due to receiving the first phone call. LPN #505 said CNA #500 was the assigned shower aide for the day of the incident and she had given a lot of resident's showers. LPN #505 denied any additional involvement in the incident or the facility's internal investigation of the incident.</p> <p>On 12/05/24 at 12:55 P.M., an interview with CNA #507 revealed she was aware of a video taken of a resident who was naked, but she denied any involvement in the incident or the facility's internal investigation of the incident.</p> <p>On 12/05/24 at 1:42 P.M., an interview with CNA #508 revealed on 11/27/24 she was assigned to complete showers with CNA #500 on 11/27/24. She said CNA #509 and CNA #510 brought Resident #28 to the shower room to clean her up after incontinence and CNA #500 refused the shower because Resident #28 was showered the prior day. CNA #508 said she offered to assist CNA #509 and CNA #510 with the shower as soon as she finished assisting another resident. CNA #508 stated there was a large amount of liquid feces when they removed Resident #28's clothing. CNA #508 stated that she, along with CNA #509 and CNA #510, assisted Resident #28 in getting cleaned up and then Resident #28 was incontinent again, which required her to be cleaned up again. CNA #508 said Resident #28 had explosive diarrhea, was cleaned up again, and was assessed by RN #502. CNA #508 said Resident #28 was positioned over the toilet in the shower chair due to the frequency of her incontinence. CNA #508 said there was feces all over the floor and she began cleaning it up. CNA #508 stated while she was cleaning up the floor, she looked over at CNA #500 and noticed she was recording on her phone. CNA #508 said she asked CNA #500 why she was recording because that was a HIPAA violation and CNA #500 responded I know, but it's funny. CNA #508 said Resident #28 was cleaned up and taken back to her room, then a few minutes later the nurses came and got CNA #500 from the shower room.</p> <p>On 12/05/24 at 3:35 P.M., an interview with CNA #509 revealed on 11/27/24 she was working on Resident #28's unit with CNA #510. CNA #509 stated Resident #28 had an episode of incontinence after dinner that required a shower to clean the resident. CNA #509 said Resident #28 was taken to the shower room, where CNA #500 refused to complete the shower because Resident #28 had been showered the day before. CNA #509 said she was in and out of the shower room cleaning up the hallway from where they transported Resident #28 to the shower room. CNA #509 said CNA #500, CNA #508, and CNA #510 were in the shower room with Resident #28. CNA #509 stated CNA #500 was on her phone in the shower room and that was nothing new because CNA #500 was always on her phone texting people. CNA #509 said Resident #28 kept having diarrhea and had to be showered again. CNA #509 said she tried to get Resident #28 dressed, but the resident was hard to position in the shower chair and she could not get Resident #28's clothes on all the way. CNA #509 stated Resident #28's shirt was not all the way down, leaving her breasts exposed, and she had no pants on. CNA #509 stated once Resident #28 was cleaned up and dressed, she was taken back to her room and put in bed by CNA #509 and CNA #510. CNA #509 said CNA #500 and CNA #508 continued giving showers. CNA #509 said a few minutes after all that occurred, she heard RN #502 tell CNA #500 that she needed to speak with her and needed to see her cell phone. CNA #509 said she was unaware that a video was taken until RN #502 asked to see CNA #500's phone. CNA #509 further stated she did not see the video on Snapchat the day the video was taken, but stated she did see the video shared to a local Facebook page a few days after the incident occurred. CNA #509 reported the video shared to Facebook had since been removed.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 12/05/24 at 3:50 P.M., an interview with CNA #510 revealed on 11/27/24 Resident #28 was incontinent and had feces under her chair. CNA #510 said it was easier to clean Resident #28 up in the shower. CNA #510 said CNA #509 assisted with cleaning the floor in the hallway and CNA #508 assisted with showering Resident #28 after multiple episodes of incontinence in the shower room. CNA #510 stated CNA #500 was on her phone in the shower room but that was nothing new because CNA #500 was always on her phone texting while at work.</p> <p>Review of the facility's policy on personal telephone use, dated January 2009, indicated cell phones that were not provided by the company were not to be permitted to be ON in the building during working hours and they should not be on an employee's person.</p> <p>On 12/05/24 at 4:45 P.M., an interview with the Administrator, DON, and Regional QA Nurse #503 revealed facility staff were permitted to use their phones at the nurse's stations to contact medical practitioners and resident family members, but staff should not have their personal cell phones in resident care areas or while providing personal care.</p> <p>On 12/09/24 at 9:10 A.M., an interview with the Administrator confirmed the facility's personal phone policy indicated non-company cell phones were to be turned off during working hours and staff should not have their personal cell phones on them while at work. The Administrator further stated that was an outdated policy that needed revision because facility staff utilized their personal cell phones to communicate with practitioners and staffing agencies while working in the facility.</p> <p>On 12/09/24 at 10:50 A.M., an interview with Regional QA Nurse #503 verified the facility investigated the incident involving Resident #28 and initially determined the allegation of abuse was unsubstantiated. Regional QA Nurse #503 further stated she did not think there was any harm to Resident #28 because staff believed the resident was unaware of the incident.</p> <p>On 12/10/24 at 8:00 A.M., an interview with Regional QA Nurse #503 revealed the facility had abuse prevention policies in place and staff were educated on those policies. Regional QA Nurse #503 said it was not the facility's fault that CNA #500 chose not to follow the facility's abuse prevention policy. During a follow-up interview on 12/10/24 at 10:10 A.M., Regional QA Nurse #503 confirmed the incident involving Resident #28 could be considered abuse based on the reasonable person concept.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy on social media use, dated January 2021, indicated staff members should exercise care when participating in social media, follow the same behavioral standards online that they would while engaging in personal and professional interactions, and staff members were accountable for anything they posted to social media about the facility and its staff or residents. The definition of social media, as defined in the facility's policy, included all forms of public, web-based communication, whether existing at the time of this policy's adoption or created at a future date, including but not limited to the following: social networking sites (e.g. Facebook, LinkedIn), video and photo-sharing websites (e.g. Instagram, YouTube), micro-blogging sites (e.g. Twitter, Snapchat, TikTok), blogs (e.g. corporate blogs, personal blogs, media-hosted blogs), forums and discussion boards (e.g. Yahoo! groups, Google groups), and collaborative publishing (e.g. Wikipedia). The policy indicated staff members were responsible for anything they posted online, must be respectful to the facility and its staff and residents, ensure communications or postings do not violate any of the facility's policies including HIPAA, must not express pornographic or indecent content, never post anything to a social media site or on the internet that interferes with resident obligations, and remember everything written online can be traced back to its author. Violations of this policy would result in discipline up to and including discharge.</p> <p>Review of the facility's policy on abuse prevention, dated 03/2023, indicated the facility would protect all residents from verbal, mental, physical, emotional, or financial abuse by staff, families, residents, visitors or outside ancillary service employees or in any situation that would be harmful to the resident. The definition of mental abuse, as defined in the facility's policy, included nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate a resident. The definition of neglect, as defined in the facility's policy, included failures of the facility, its employees or service providers to provide a resident with goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress. The policy also indicated all alleged, suspected, or observed abuse, neglect, and/or mistreatment of a resident would be thoroughly investigated by the Administrator and DON until a determination could be made as to whether abuse had occurred. If an employee was suspected of abuse, neglect, or mistreatment of a resident, they would be suspended of their duties until the investigation was complete.</p> <p>Review of the facility's policy on abuse allegation investigations, dated 05/2024, indicated the facility would immediately investigate and report any allegation of abuse. The facility Administrator and/or designee would ensure steps were taken to protect the resident from further abuse during the investigation, ensure a physical assessment of the resident was completed to determine if any injury or trauma occurred, ensure the alleged perpetrator was immediately suspended (facility staff) or requested to leave the building (visitor), ensure the allegation was reported to the State Agency, report the incident to local law enforcement if the allegation/incident was a suspected crime, interview the resident about the alleged incident as soon as possible, observe and assess if the resident had any changes as a result of the alleged incident, notify the resident's attending physician and the resident's legal representative of the alleged incident, document the date and time of the alleged incident as well as the location of the alleged incident, interview all staff and potential witnesses, secure staff witness statements, interview and assess (as applicable) other residents that may be at-risk, interview the alleged perpetrator and obtain a statement, ensure all interviews with staff and residents are witnessed and documented, review the employee file of the alleged perpetrator (if applicable), complete the investigation and document the determination if the alleged incident is verified/not verified or if the evidence was inconclusive. All allegations of abuse and investigations would be reviewed by the facility's quality assurance committee to determine if additional measures were necessary.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>This deficiency represents non-compliance investigated under Complaint Number OH00160397 and Complaint Number OH00160368.</p>		