STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365746	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Health Care Center	907 Aurora Rd Sagamore Hills, OH 44067

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)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on interview, review of a self-reported incident (SRI), record review and review of the facility policies, the facility failed to ensure residents were free from unauthorized video recordings by staff. This affected one resident (#4) of three residents reviewed for abuse. The facility census was 88. Findings include: Review of Resident #4's medical record revealed an admitted [DATE] and diagnoses including Alzheimer's disease, type II diabetes, dementia with other behavioral disturbance, depression, anxiety, and adult failure to thrive. Review of Resident #4's quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #4 had short and long term memory problems and severe cognitive impairment with continuous inattention and disorganized thinking. Resident #4 rejected care one to three days in the seven-day look-back period. Resident #4 required substantial to maximum assistance with toileting, set up to dress her upper body, supervision to dress her lower body and supervision for sitting to standing and to complete toileting transfers. Resident #4 was frequently incontinent of bowel and bladder. (continued on next page)

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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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility self-reported incident dated 10/23/24 revealed on the morning of 10/23/24, Housekeeper #344 reported to the Director of Nursing (DON) that a friend of hers (Community Person #350) called her to let her know he saw a live feed on a web-based application called Tagged where a facility staff member was at work in the resident ' s room with the resident in the background of the video. He reported he was not able to record the video but did take several screenshots (still photos) during the live feed. The DON reported this to the Administrator and an investigation was immediately started. Certified Nursing Assistant (CNA) #349 and Resident #4 were identified in the video. CNA #349 was suspended immediately pending outcome of the investigation. Interviews were completed with staff; CNA #349 denied the allegation and reported Licensed Practical Nurse (LPN) #244 was in the room while she got Resident #4 dressed as she tended to be combative. LPN #244 denied the allegation and denied seeing CNA #349's phone or a camera while in the room. Interview with Community Person (CP) #350 confirmed he saw the live video and reported the recording device was across the room from where Resident #4 was being provided care. He stated it appeared as though the employee was changing the residents' brief but at no time was Resident #4 observed to be naked or with private areas exposed to the viewer and the staff member did not make fun of the resident or disparage her in any way. Residents on the 300 hall (where Resident #4 resided) were interviewed by Social Service Designee (SSD) #325 with no additional concerns reported; Resident #4 was not able to provide coherent information when interviewed due to her advanced dementia. The facility determined the allegation to be unsubstantiated for abuse as Resident #4 was in the background of the video but the content of the video was not demeaning or humiliating to the resident. The facility disciplined CNA #349 for violation of resident privacy policies as a result of their investigation. Continued review of the facility investigation revealed a photo timed 10/23/24 at 6:59 A.M. with Resident #4 in a blouse and pants putting socks on. A second photo with the same time-stamp revealed a blurry photo of CNA #349 with Resident #4's blurry face noted in the background and the rest of Resident #4's body was not visible as CNA #349 was in the foreground. Review of a photo timed 10/23/24 at 7:02 A.M. with Resident #4 laying across her bed with her heels resting on the edge of the bed. Resident #4 had on blue socks and her top was covered but her legs including her thighs were bare. Resident #4's buttocks or private areas were not observable from the photo. Review of a photo timed 10/23/24 at 7:16 A.M. revealed CNA #349 in the facility hallway, with tubing in her hands and the room [ROOM NUMBER] is visible in the background. Interview on 11/12/24 at 10:49 A.M. with the Administrator regarding the SRI on 10/23/24 revealed Housekeeper #344 said her friend, CP #350 said an employee [CNA #349] was live in the facility in a resident's room on social media between 6:30 A.M. and 7:00 A.M. The social media application, called Tagged, was used for dating and involved users taking videos of themselves. The Administrator indicated he interviewed CP #350 by phone for the facility investigation and learned CNA #349's phone was propped up in the resident's room as she completed resident care and he did not observe Resident #4 naked. The Administrator stated as far as he was aware, no one at the facility had seen the video except CP #350. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/12/24 at 11:37 A.M. with CNA #349 revealed she worked a 16-hour shift from 10/22/24 into 10/23/24. CNA #349 stated Resident #4 was combative so did not provide care at that time and continued to care for her other residents. CNA #349 stated LPN #244 told her on her way out of the facility she needed to care for Resident #4 and they could do it together. CNA #349 stated she was on her phone watching videos on Tagged (dating application) and was unaware a user had requested to livestream. CNA #349 could not deny the livestream request and thus her phone started to record while she was in Resident #4's room. CNA #349 denied making disparaging comments to Resident #4 and indicated she was very polite. CNA #349 verified she provided personal care to Resident #4 but her breasts and perineal areas were not exposed at any time. CNA #349 explained on Tagged, a video would be live and once it was over it would not be saved anywhere as it was not posted to an account but was live content. CNA #349 was unaware if any one at the facility had seen the video and called it a lesson learned. Interview was attempted with CP #350 on 11/12/24 at 11:50 A.M. but was not successful. Interview on 11/12/24 at 11:54 A.M. with Housekeeper #344 revealed her children's father, CP #350, was on Tagged and had sent photos of Individual #4 to the DON from the livestream as he saw she was being changed, recognized the facility and was 'bothered by the situation.' Housekeeper #344 indicated she had seen the photos but not the video and indicated Resident #4's private areas were not visible in the photos. Interview was attempted with LPN #244 on 11/12/24 at 12:08 P.M. but was not successful. Interview on 11/12/24 at 12:10 P.M. with the DON revealed she helped with the SRI investigation on 10/23/23 and indicated the photos in the file were what they received from CP #350. The DON stated the only staff members aside from herself and the Administrator that had viewed the photos was Housekeeper #344 and she was unaware of anyone at the facility that had viewed the video as of the time of the interview. The DON also verified Resident #4 was not interviewable due to cognitive status. Interview was attempted with Resident #4's responsible party on 11/12/24 at 1:52 P.M. but was not successful. Follow-up interview on 11/12/24 at 2:25 P.M. with the DON verified the identified privacy concerns with Resident #4 as a result of CNA #349's phone recording the resident without her consent or knowledge. The DON confirmed CNA #349 was terminated as a result of the facility's investigation due to not meeting privacy and facility policy expectations as they could not determine abuse had occurred. Review of the policy, Personal Cell Phones, reviewed/revised 04/01/24 revealed the facility would provide quality care to its residents without interruption. The facility prohibits employees from using personal cell phones for any reason on the nursing units or in working areas of the facility. This includes calls, texts, social media or any other use of cell phones. Under no circumstances should employees take pictures, videos or any other personal representations of any resident, family member, visitor, or staff member for the purpose of personal use, social media or any other reason. Review of the policy, Resident Rights, dated 2024 revealed the resident had the right to personal privacy including medical treatment and personal care. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Master Complaint Number OH00159552 and Complaint Number OH00159466.