

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395090	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/27/2024
NAME OF PROVIDER OR SUPPLIER  Windber Woods Senior Living & Rehabilitation Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 277 Hoffman Avenue Windber, PA 15963	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>19102</p> <p>Based on review of facility policies, information provided to staff upon hire, investigation documents, and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that each resident's personal privacy was maintained for one of three residents reviewed (Resident 2).</p> <p>Findings include:</p> <p>The facility's abuse policy, dated December 14, 2023, included policies and procedures related to training, preventative measures, identifying, investigating, reporting, and protecting residents from exposure to abuse, neglect, mistreatment, and misappropriation.</p> <p>The facility's cell phone usage policy, dated December 14, 2023, indicated that cell phones were not to be used in resident care units or carried on one's body while the employee was working. No staff member was allowed to photograph a resident or their surroundings and post it on social media of any kind. Even if a resident consented, and regardless of the resident's cognitive status, abuse will be presumed and investigated whenever there was a photograph or recording of a resident, or the manner that it was used (if it demeaned or humiliated a resident).</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated March 14, 2024, indicated that the resident was cognitively impaired, had verbal behaviors, was frequently incontinent of bowel and bladder, and had diagnoses that included dementia.</p> <p>Review of information submitted by the facility, dated March 17, 2024, indicated that Nurse Aide 1 took a picture of Resident 2 on her cell phone while Resident 2 was sitting on the toilet with his pants pulled up almost the entire way, exposing a small portion of his upper leg. The picture of the resident was from the waist down and the resident's face was not in the picture. The picture showed the resident sitting on the commode with his pants pulled almost all the way up, exposing a small portion of his upper leg. The picture of the resident was then posted on social media.</p> <p>Investigative interview statements from Nurse Aide 1, dated March 17, 2024, confirmed that she took a picture of Resident 2 while he was on the toilet.</p> <p>Investigative interview statements from Nurse Aide 2, dated March 17, 2024, confirmed that she saw the picture on social media that Nurse Aide 1 took of Resident 2 sitting on the toilet.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Nursing Home Administrator on March 27, 2024, at 11:04 a.m. confirmed that Nurse Aide 1 took a picture of Resident 2 on the toilet and posted it on social media, and revealed that employees were not to take any pictures of residents on their cell phones.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 201.29(j) Resident Rights.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</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>19102</p> <p>Based on review of facility policies, clinical records and investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from mental abuse for one of three residents reviewed (Resident 2).</p> <p>Findings include:</p> <p>The facility's abuse policy, dated December 14, 2023, included policies and procedures related to training, preventative measures, identifying, investigating, reporting, and protecting residents from exposure to abuse, neglect, mistreatment, and misappropriation.</p> <p>The facility's cell phone usage policy, dated December 14, 2023, indicated that cell phones were not to be used in resident care units or carried on one's body while the employee was working. No staff member was allowed to photograph a resident or their surroundings and post it on social media of any kind. Even if a resident consented, and regardless of the resident's cognitive status, abuse will be presumed and investigated whenever there was a photograph or recording of a resident, or the manner that it was used (if it demeaned or humiliated a resident).</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated March 14, 2024, indicated that the resident was cognitively impaired, had verbal behaviors, was frequently incontinent of bowel and bladder, and had diagnoses that included dementia.</p> <p>Review of information submitted by the facility, dated March 17, 2024, indicated that Nurse Aide 1 took a picture of Resident 2 on her cell phone while Resident 2 was sitting on the toilet with his pants pulled almost all the way up. The picture of the resident was from the waist down and the resident's face was not in the picture. The picture showed the resident sitting on the commode with his pants pulled up almost the entire way, exposing a small portion of his upper leg. The picture of the resident was then posted on social media.</p> <p>Investigative interview statement from Nurse Aide 1, dated March 17, 2024, confirmed that she took a picture of Resident 2 while he was on the toilet.</p> <p>Investigative interview statement from Nurse Aide 2, dated March 17, 2024, confirmed that she saw the picture on social media that Nurse Aide 1 took of Resident 2 sitting on the toilet.</p> <p>Interview with the Nursing Home Administrator on March 27, 2024, at 11:04 a.m. confirmed that Nurse Aide 1 took a picture of Resident 2 on the toilet and posted it on social media, and revealed that employees were not to take any pictures of residents on their cell phones.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>(continued on next page)</p>		

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