STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375387	A. BUILDING _____ B. WING _____	04/05/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEARE MANOR	1300 NORTH DRIVE HARTSHORNE, OK 74547

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 04/04/18, an immediate jeopardy (IJ) situation was determined to exist due to the failure of the facility to prevent abuse and protect a resident from abuse by a staff member who photographed resident #1 with a personal cellular (cell) phone and distributed it to another staff member who viewed and then showed the photo to other staff members. On 03/30/18 certified nurse aide (CNA) #1 used a personal cell phone to photograph resident #1 without her consent. The resident was naked in bed, awake, and looking at the camera. The resident's bedding hung off the side of the bed and on to the floor and the resident had experienced a bowel movement per the comment sent with the photograph. The CNA sent the photograph and comment in a text message to CNA #2 who showed the photo to other staff members. The staff members who viewed the photo did not report the incident to the director of nursing (DON), the facility administrator (adm), or to Oklahoma State Department of Health (OSDH) until 04/02/18. On 04/04/18 at 11:19 a.m., OSDH was notified and verified the IJ situation. On 04/04/18 at 11:25 a.m., the adm was notified an IJ existed related to the facility's failure to prevent and protect the resident from abuse. On 04/04/18 at 12:42 p.m., an acceptable plan of removal was received from the administrator. The plan of removal documented the following: Plan of Removal The Plan of Removal for correcting the Immediate Jeopardy Situation regarding Abuse of (name redacted, resident #1) is: - Staff (name redacted, CNA #1) responsible for taking the picture has been terminated. - Staff responsible for showing the picture to others (name redacted, CNA #2) is suspended at this time and will be terminated. - Nurses, who staff claim they reported incident to ((name redacted, licensed practical nurse (LPN) #1) and (name redacted, LPN #2)) are currently suspended and will be terminated. - Staff, who were shown the picture and did not report it until Monday, ((names redacted, CNA #3, housekeeper #2, housekeeper #3, and CNA #4)) will be terminated for failure to report abuse within the required time frame. - Remaining staff will be in-serviced on: - Abuse Prohibition Policy - Resident Rights - Social Media Policy - Staff will not be allowed to carry cell phones or other electronic devices in the building. - In-service will be held today (4/4/18) at 1 PM. - Any staff who does not attend will be in-serviced by phone by 3PM today. This plan of correction will be completed by 3 PM. On 04/05/18 at 9:55 a.m., the facility was notified the IJ was removed on 04/04/18 at 4:43 p.m., when all components of the plan of removal had been completed. The deficient practice remained at an isolated level of actual harm. Based on observation, interview, and record review, it was determined the facility failed to ensure residents were free from sexual abuse for one (#1) of four residents sampled for abuse and neglect. The facility failed to prevent a staff member from photographing a naked resident and distributing the photograph to another staff member who subsequently showed multiple staff members over the course of two days. The director of nursing (DON) identified 37 residents who resided in the facility. Findings: A facility policy on social media documented, Posting pictures, recordings, or names of any resident on social media is a violation of resident privacy and confidentiality and is grounds for immediate termination .Any other photos or recordings of residents are strictly prohibited. A facility policy on abuse prohibition documented, Abuse includes any form of physical, verbal, or sexual abuse, involuntary seclusion, neglect, misappropriation of property, and corporal punishment. If you have any concerns regarding these issues, you have the duty to contact us immediately through one or more of the following resources: The Administrator/Designee, DON, ADON, Charge Nurse. The policy documented one type of sexual abuse as Causing, permitting, encouraging, or allowing the photographing, filming, or depicting of the person, if the person knew or should have known, that the resulting photograph, film, or depiction was obscene or pornographic. Resident #1 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A significant change assessment, dated 12/01/17, documented the resident was moderately impaired with daily decision making. The assessment documented the resident required extensive assistance with most activities of daily living and did not walk. A quarterly assessment, dated 03/01/18, documented the resident was severely impaired in cognition. The assessment documented the resident required limited assistance with transfers, extensive assistance with dressing, hygiene, and toileting, and did not walk. An incident report form, submitted to OSDH as an initial report on 04/02/18 at 3:49 p.m., documented the DON was made aware of the photograph of resident #1 on 04/02/18 at 1:43 p.m. The incident report documented the facility had determined CNA #1 had photographed the resident on 03/30/18 and had sent the photo to CNA #2. The incident report documented CNA #2 showed the photo to other staff members. The incident report documented CNA #3 was shown the photo on 04/01/18 and reported it to licensed practical nurse (LPN) #1 on the same day. An undated handwritten statement, signed by CNA #2, documented she received a photo by text message of resident #1 on 03/30/18 at 11:43 p.m. The statement documented the resident was lying in her bed with the sheets and blankets hanging off her bed, covered with poop. The statement documented that on 03/31/18 she showed a co-worker the photo in an attempt to obtain advice on what to do. The statement documented the co-worker instructed her to inform the charge nurse. The statement documented the CNA told her charge nurse and was instructed to report the photo and incident to the DON when the DON returned to work. The statement documented the CNA showed the photo to LPN #2 and CNA #3. An undated handwritten statement, signed by CNA #3, documented CNA #2 had shown her a picture of the resident with no clothes on and a sheet beside her. The statement documented the photo was sent from CNA #1 and had a caption of in the middle of taking a (s***). The statement documented she told LPN #1 about the photo. The statement documented that on 04/02/18 she reported the incident and photo to the DON as soon as she got to work. A nurse note, dated 04/02/18 at 5:24 p.m., documented the resident was observed by the DON and another LPN and had no signs of trauma.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.

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F 0600 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 1) A typed and signed statement from LPN #2, dated 04/02/18, documented the LPN had no knowledge of the photo or the incident surrounding the photo. The statement documented, apparently it was reported to admin that (name redacted) CNA (#1) had taken a naked pic of a res Friday night and was either showing it to some of the other aides or texting it to them or Snapchatting it to them. The statement documented she wasn't sure how they were passing it around. A handwritten statement from housekeeper #2, dated 04/03/18, documented she was shown a photo of resident #1 on Saturday, (MONTH) 30th, at 4:00 pm. The statement documented housekeeper #3 was right beside her, and CNA #2 and CNA #4 were sitting on the couch. The statement documented a conversation between CNA #2 and housekeeper #2 regarding CNA #1 who had quit. The statement documented the housekeeper was instructed by CNA #2 to come look at this message. The statement documented she observed a photo of the resident who was naked and looking at the camera with no blankets or covers on her. The statement documented the housekeeper told the others this was a big violation and needed to be reported. The statement documented she planned to report it on Monday (04/02/18). A handwritten statement from LPN #1, dated 04/03/18, documented the LPN was not on duty at the time the photo was taken. The statement documented the LPN denied seeing the photo but was told about the photo on 04/01/18. The statement documented she was told the photo had been sent to CNA #2. The statement documented the LPN was told CNA #2 had taken the photo to the DON. The statement documented the LPN thought the incident had been reported and did not report it herself. A handwritten statement from CNA #1, dated 04/03/18, documented, I took a picture as inside joke with my phone and sent it to a co-worker after taking and sending the photo I then deleted the photo. To my knowledge nobody else had seen the photo. Please give phone number to family so that I can appoleglse (sic) to them. On 04/04/18 at 8:55 a.m., the DON was asked what the facility had done to protect the resident and prevent the reoccurrence of abuse. The DON reported CNA #2 was suspended and CNA #1 had quit. She stated LPN #1 and LPN #2 had been suspended and reported to the Oklahoma Board of Nursing. She stated no cell phones were allowed on the floor and the facility had a mandatory in-service planned for 04/05/18. On 04/04/18 at 9:47 a.m., the adm was interviewed and reported she had been working at another facility and had called on 04/02/18 at approximately 2:00 p.m. to see if everything was OK. She stated she was asked by the front office manager if she had heard about the incident. The adm reported she was told CNA #1 had taken a naked photo of the resident and sent it to another staff member who was showing it around. She stated she reported it to the corporate nurse and was informed this was abuse and was instructed to go to the facility immediately and start the investigation and reporting process. She stated the police were notified and took a statement from CNA #2. The adm was asked what steps were put in place to protect the resident and to prevent reoccurrence of the abuse. She reported the facility planned to move the resident closer to the nursing station but had not done so as yet. The adm reported she suspended the two LPNs and CNA #2. She stated she planned on having an in-service for all the staff but had not done it yet. On 04/04/18 at 2:17 p.m., the resident was observed in her wheelchair in the living room area. The resident was clean, dressed, and showed no signs or symptoms of distress. An attempt was made to interview the resident but she was not able to form coherent sentences. When asked if she remembered a staff member taking a photo of her, she replied, No.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to implement their abuse prohibition policy for one (#1) of four residents sampled for abuse and neglect. The facility failed to prevent a staff member from photographing a naked resident and distributing the photograph to another staff member who subsequently showed multiple staff members over the course of two days. Staff members failed to report to the director of nursing (DON), the administrator (adm), and/or Oklahoma State Department of Health (OSDH) for over two days from the date of the incident. The director of nursing (DON) identified 37 residents who resided in the facility. Findings: A facility policy on social media documented, Posting pictures, recordings, or names of any resident on social media is a violation of resident privacy and confidentiality and is grounds for immediate termination .Any other photos or recordings of residents are strictly prohibited. A facility policy on abuse prohibition documented, Abuse includes any form of physical, verbal, or sexual abuse, involuntary seclusion, neglect, misappropriation of property, and corporal punishment. If you have any concerns regarding these issues, you have the duty to contact us immediately through one or more of the following resources: The Administrator/Designee, DON, ADON, Charge Nurse. The policy documented one type of sexual abuse as Causing, permitting, encouraging, or allowing the photographing, filming, or depicting of the person, if the person knew or should have known, that the resulting photograph, film, or depiction was obscene or pornographic. Resident #1 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A significant change assessment, dated 12/01/17, documented the resident was moderately impaired with daily decision making. The assessment documented the resident required extensive assistance with most activities of daily living and did not walk. A quarterly assessment, dated 03/01/18, documented the resident was severely impaired in cognition. The assessment documented the resident required limited assistance with transfers, extensive assistance with dressing, hygiene, and toileting, and did not walk. An incident report form, submitted to OSDH as an initial report on 04/02/18 at 3:49 p.m., documented the DON was made aware of the photograph of resident #1 on 04/02/18 at 1:43 p.m. The incident report documented the facility had determined CNA #1 had photographed the resident on 03/30/18 and had sent the photo to CNA #2. The incident report documented CNA #2 showed the photo to other staff members. The incident report documented CNA #3 was shown the photo on 04/01/18 and reported it to licensed practical nurse (LPN) #1 on the same day. An undated handwritten statement, signed by CNA #2, documented she received a photo by text message of resident #1 on 03/30/18 at 11:43 p.m. The statement documented the resident was lying in her bed with the sheets and blankets hanging off her bed, covered with poop. The statement documented that on 03/31/18 she showed a co-worker the photo in an attempt to obtain advice on what to do. The statement documented the co-worker instructed her to inform the charge nurse. The statement documented the CNA told her charge nurse and was instructed to report the photo and incident to the DON when the DON returned to work. The statement documented the CNA showed the photo to LPN #2 and CNA #3. An undated handwritten statement, signed by CNA #3, documented CNA #2 had shown her a picture of the resident with no clothes on and a sheet beside her. The statement documented the photo was sent from CNA #1 and had a caption of in the middle of taking a (s***). The statement documented she told LPN #1 about the photo. The statement documented that on 04/02/18 she reported the incident and photo to the DON as soon as she got to work. A nurse note, dated 04/02/18 at 5:24 p.m., documented the resident was observed by the DON and another LPN and had no signs of trauma. A typed and signed statement from LPN #2, dated 04/02/18, documented the LPN had no knowledge of the photo or the incident surrounding the photo. The statement documented, apparently it was reported to admin that (name redacted) CNA (#1) had taken a naked pic of a res Friday night and was either showing it to some of the other aides or texting it to them or Snapchatting it to them. The statement documented she wasn't sure how they were passing it around. A handwritten statement from housekeeper #2, dated 04/03/18, documented she was shown a photo of resident #1 on Saturday, (MONTH) 30th, at 4:00 pm. The statement documented housekeeper #3 was right beside her, and CNA #2 and CNA #4 were sitting on the couch. The statement documented a conversation between CNA #2 and housekeeper #2 regarding CNA #1 who had quit. The statement documented the housekeeper was instructed by CNA #2 to come look at this message. The statement documented she observed a photo of the resident who was naked and looking at the camera with no blankets or covers on her. The statement documented the housekeeper told the others this was a big violation and needed to be reported. The statement documented she planned to report it on Monday (04/02/18). A handwritten statement from LPN #1, dated 04/03/18, documented the LPN was not on duty at the time the photo was taken. The statement documented the LPN denied seeing the photo but was told about the photo on 04/01/18. The statement documented she was told the photo had been sent to CNA #2. The statement documented the LPN was told CNA #2 had taken the photo to the DON. The statement documented the LPN thought the incident had been reported and did not report it herself. A handwritten statement from CNA #1, dated 04/03/18, documented, I took a picture as inside joke with my phone and sent it to a co-worker after taking and sending the photo I then deleted the photo. To my knowledge nobody else had seen the photo.

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) Please give phone number to family so that I can appoleglse (sic) to them. On 04/04/18 at 8:55 a.m., the DON was asked what the facility had done to protect the resident and prevent the reoccurrence of abuse. The DON reported CNA #2 was suspended and CNA #1 had quit. She stated LPN #1 and LPN #2 had been suspended and reported to the Oklahoma Board of Nursing. She stated no cell phones were allowed on the floor and the facility had a mandatory in-service planned for 04/05/18. On 04/04/18 at 9:47 a.m., the adm was interviewed and reported she had been working at another facility and had called on 04/02/18 at approximately 2:00 p.m. to see if everything was OK. She stated she was asked by the front office manager if she had heard about the incident. The adm reported she was told CNA #1 had taken a naked photo of the resident and sent it to another staff member who was showing it around. She stated she reported it to the corporate nurse and was informed this was abuse and was instructed to go to the facility immediately and start the investigation and reporting process. She stated the police were notified and took a statement from CNA #2. The adm was asked what steps were put in place to protect the resident and to prevent reoccurrence of the abuse. She reported the facility planned to move the resident closer to the nursing station but had not done so as yet. The adm reported she suspended the two LPNs and CNA #2. She stated she planned on having an in-service for all the staff but had not done it yet.
F 0608 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures to ensure (1) employees report any suspicion of a crime against any resident, according to timelines; (2) post the notice of employee rights; and (3) prohibit and prevent retaliation for reporting.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to implement their abuse prohibition policy to ensure reporting of a crime for one (#1) of four residents sampled for abuse and neglect. Staff members, who viewed and shared the photo, failed to report to the director of nursing (DON), the administrator (adm), and/or Oklahoma State Department of Health (OSDH), after being shown a nude photo of resident #1 for over two days from the date of the photo was taken and shared. The director of nursing (DON) identified 37 residents who resided in the facility. Findings: A facility policy on social media documented, Posting pictures, recordings, or names of any resident on social media is a violation of resident privacy and confidentiality and is grounds for immediate termination .Any other photos or recordings of residents are strictly prohibited. A facility policy on abuse prohibition documented, Abuse includes any form of physical, verbal, or sexual abuse, involuntary seclusion, neglect, misappropriation of property, and corporal punishment. If you have any concerns regarding these issues, you have the duty to contact us immediately through one or more of the following resources: The Administrator/Designee, DON, ADON, Charge Nurse. The policy documented one type of sexual abuse as Causing, permitting, encouraging, or allowing the photographing, filming, or depicting of the person, if the person knew or should have known, that the resulting photograph, film, or depiction was obscene or pornographic. Resident #1 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A significant change assessment, dated 12/01/17, documented the resident was moderately impaired with daily decision making. The assessment documented the resident required extensive assistance with most activities of daily living and did not walk. A quarterly assessment, dated 03/01/18, documented the resident was severely impaired in cognition. The assessment documented the resident required limited assistance with transfers, extensive assistance with dressing, hygiene, and toileting, and did not walk. 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She stated she reported it to the corporate nurse and was informed this was abuse and was instructed to go to the facility immediately and start the investigation and reporting process. She stated the police were notified and took a statement from CNA #2. The adm was asked what steps were put in place to protect the resident and to prevent reoccurrence of the abuse. She reported the facility planned to move the resident closer to the nursing station but had not done so as yet. The adm reported she suspended the two LPNs and CNA #2. She stated she planned on having an in-service for all the staff but had not done it yet.

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