DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/05/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495281	A. BUILDING ______ B. WING ______	R-C 08/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE REHAB CENTER	300 BLUE RIDGE STREET MARTINSVILLE, VA 24112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit was conducted 8/14/18 through 8/15/18 to the 6/28/18 standard survey. The provider was found to have a past noncompliance deficiency with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the revisit. The census in this 300 certified bed facility was 230 at the time of the survey. The survey sample consisted of 18 current Resident reviews.	{F 000}		
{F 550} SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	{F 550}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 9-5-18

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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provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, facility document review and in the course of a complaint investigation, it was determined that the facility staff failed to provide privacy, dignity and respect for 2 of 19 Residents in the sample survey, Resident #100 and Resident #102.

Past noncompliance: no plan of correction required.

The Findings included:

This Complaint was generated from a Facility Reported Incident (FRI) that was received in the State Agency on 7/30/18. This Complaint was investigated during a Revisit Survey and Complaint Survey done on 8/14/18 through 8/15/18.

The FRI/Complaint alleged that on 7/30/18 a Housekeeping Staff member videoed two (2)

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{F 550}	Continued From page 2 Residents during a sexual contact and then showed the video to several other staff members. The Residents will be identified as Resident #100 and Resident #102. On August 15, 2018 at 10 a.m., the surveyor notified the Director of Professional Services (DOPS) of the Complaint. The DOPS stated that the incident happened on the weekend on 7/28/18. The DOPS stated that a staff member called him on 7/29/18, and alerted him that Resident #100 and Resident #102 had sexual contact in the dining room. The DOPS stated that he was told that a Housekeeping staff member had videoed the incident and had shown the video to several other staff members. The DOPS stated that he had come into the facility and started an investigation. The DOPS stated that he called the Housekeeping Manager and told him to come in and help with the investigation. The DOPS stated that the Housekeeping staff member, who videoed the sexual contact between Resident #100 and Resident #102, along with three other staff members had been suspended pending the investigation. The DOPS stated that during the investigation he had notified the State Agency, Adult Protective Services and the Ombudsman of the occurrence. The DOPS stated that multiple staff members were interviewed and all staff was in-serviced about the facility policy and procedure for taking pictures and videos of the residents. The DOPS stated that what had been reported to him, was that Resident #102 and Resident #100 were in the dining room. Resident #102 asked Resident #100 to play with her "titties and to put his hands down her pants. And that if he, Resident #100, did a good job she would give him a couple of drinks." The DOPS stated that a Housekeeping Staff	{F 550}		

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member had videoed the occurrence and had shown the video to other staff members.

Resident #100 was a 73-year-old male who was originally admitted on 7/16/09. Admitting diagnoses, included, but were not limited to: diabetes mellitus, dementia, schizophrenia, bipolar, depression, anxiety, hypertension and acute renal failure.
The most current Minimum Data Set (MDS) assessment located in the clinical record was a Significant Change MDS assessment with an Assessment Reference Date (ARD) of 6/21/18. The facility staff coded that Resident #100 had a Cognitive Summary Score of 11. The facility staff also coded that Resident #100 required extensive assistance (3/2) with Activities of Daily Living (ADL's).

Resident #102 was a 71-year-old female who was originally admitted on 2/22/14. Admitting diagnoses included, but were not limited to: diabetes mellitus, dementia, anxiety, paranoid schizophrenia, depression and hypertension.
The most current MDS located in the clinical record was an Annual MDS assessment with an ARD of 5/31/18. The facility staff coded that Resident #102 had a Cognitive Summary Score of 15. The facility staff coded that Resident #102 required extensive assistance (3/2) with ADL's.

On August 15, 2018 at 9:30 a.m., the surveyor reviewed the investigational details regarding the incident with the DOPS.
The DOPS reviewed the documentation with the surveyor. The first document verified that the facility notified the State Agency, Adult Protective Agency and the Ombudsman of the occurrence.

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The facility also provided a pamphlet titled, "Privacy Compliance." The pamphlet read in part ... "PRIVACY RULE IN A NUTSHELL ...The Rule protects a residents fundamental right to privacy and confidentially."

Additional documentation provided by the facility were interviews with Resident #100 and Resident #102, five housekeeping/laundry staff members and two Licensed Practical Nurses (LPN's).

The interviews documented that Resident #100 and Resident #102 were in the dining room. Resident #100 stated that Resident #102 asked him to put his hand down Resident #102's pants and to feel her "tits" and she would give him a couple of drinks.
Resident #102 stated that they, Resident #100 and Resident #102, were just "fooling around" and that she, Resident #102, had asked him to "do it."

Interviews with the staff documented that the housekeeping staff member videoed Resident #100 and #102 engaging in a sexual encounter in the dining room and the showed the video to three housekeeping/laundry staff.

The facility also provided the employee records of the four employees that either took the video or who viewed the video that had been taken of Resident #100 and Resident #102. In each employee record, it documented the suspension of the four employees during the investigation. In addition, an in-service was titled, "The Seven Key Components in the Direction and Prevention of Abuse" was reviewed and signed by each of the four employees. Additionally, the facility handbook that addressed HIPAA (Health

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Information Protection and Privacy Act) was reviewed and signed by each employee and was located in the employee records. The facility also reviewed Resident Rights with each employee and a signed copy was in each of the four employees records. Lastly, the employee record of the housekeeping staff member who videoed Resident #100 and #102 documented that the housekeeping staff member was terminated.

The DOPS stated that all staff had been re-educated on August 4, 2018 regarding types and examples of "Abuse" and the facility having no tolerance for abuse. Additionally, the facility Policy and Procedure titled, "Abuse/Neglect and Misappropriation of Funds" was reviewed with the staff.

The DOPS also hand delivered a Plan of Correction (POC) that the identified the following:

"Plan of Correction August 2, 2018
Videotaping/Photographing Residents.
1. Corrective action for those residents found to be affected by the deficient practice has been accomplished by an investigation into the allegation. Employees not reporting the incident were disciplined and suspended for three days. Employee who took the video was terminated.
2. All residents have the potential to be affected by the deficient practice. Residents will be protected from invasion of their privacy that might occur from use of residents photographs, videotapes, etc. which violates their resident right as to privacy, respect, and dignity (violation of HIPAA).
3. To assure that the deficient practice will not recur, all staff have been re-inserviced that they are not to videotape, photograph or record

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residents. Written consent must be obtained from the resident or representative prior to being photographed, videotaped, etc.
4. All staff have been re-inserviced that they are not to videotape/photograph residents. The Administrator, Director of Professional Services, Director of Nursing, unit coordinators and Quality Assurance Team members will monitor during their rounds to assure that staff are not using their cell phones while on duty. Any staff found to be using their cell phones while on duty will be disciplined accordingly.
5. Facility will be in substantial compliance by August 6 2018."

Additionally, the DOPS hand delivered the meeting minutes of the facility Quality Assurance (QA) meeting held on August 2, 2018.

The QA minutes identified that the QA committee discussed "No videotaping or pictures if residents-inservice done. Need forms returned to (name of staff member withheld)."

The survey team met with the Administrator and DOPS on August 15, 2018 at 2:45 p.m. The surveyor notified the Administrative Team (AT) of the Complaint. The surveyor notified the AT that the Complaint is SUBSTANTIATED with a Past Non-Compliance related to privacy and dignity.

No additional information was provided to the survey team prior to exiting the facility as to why the facility staff failed to promote dignity, respect and privacy for Residents #100 and #102.

This Complaint is SUBSTANTIATED with a Past Non-Compliance.