CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555124	A. BUILDING _____ B. WING _____	07/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gridley Healthcare & Wellness Centre, LLC	246 Spruce St, Gridley, CA 95948-2216 BUTTE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit: CLASS B CITATION -- PATIENT RIGHTS 23-2498-0011221-S Complaint(s): CA00397188, CA00396903 Representing the Department of Public Health: Surveyor ID # 29635, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. 1418.91(a) Health & Safety Code: Fail to Report Alleged Abuse (a)A long-term health care facility shall report all incidents of alleged abuse or suspected abuse of a resident of the facility to the department immediately, or within 24 hours. The facility failed to operationalize their abuse prevention policies when incidents of abuse and mistreatment of residents were not investigated or reported to the department within 24 hours. This resulted in the offending CNAs continuing to work with residents which jeopardized resident safety and well-being. On 5/1/14, the facility's undated policy to address abuse prevention, investigation, and reporting		**1418.91** **Corrective action for residents affected by the deficient practice.** The facility Administrator terminated the employees involved in incident on 07/15/2014. As residents became identified facility notified Department of Public Health, resident responsible party and conducted it's own assessment and assured protection to the residents of the and facility. The Administrator on record at the time of 5/13/14 is no longer employed at this facility. **Corrective action for other residents with potential to be affected by the deficient practice.**	3.28.15

Event ID:N0GI11 3/18/2015 9:41:43AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature] LIDA R TREVINO	Administrator	3-19-15

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 4

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. Except for nursing homes, the findings 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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	indicated that any allegations of abuse would be investigated immediately. The policy indicated that the purpose of the policy was to protect residents from abuse, neglect and mistreatment. The policy indicated gestured language that was derogatory or disparaging, was considered abuse, regardless of the resident's age, ability to comprehend, or disability. The policy indicated "mental abuse", included humiliation and harassment of the resident. The policy indicated that facility staff who had witnessed or who believed that a resident had been a victim of mistreatment or abuse, must immediately report, or cause a report to be made of the mistreatment. The policy indicated that the facility staff must not knowingly fail to report an incident of mistreatment or other offense. The policy indicated that the allegation of abuse would be reported to the department of public health within 24 hours. The facility's employee handbook, dated 4/2013, indicated that the use of personal communication devices, such as cellular (cell) phones, was prohibited during normal work hours and in all work areas. On 5/5/14 at 9:30 am during an interview, CNA G explained that on 4/29/14, during the day shift, she made a report to the Administrator. CNA G reported that CNA A had been using the snap chat application (app) (enables real time photographs and video to be displayed for a few seconds on another person's cellphone, but is not saved on either device) to send pictures of residents that were inappropriately exposed and/or appeared to be		Any resident with an allegation of abuse and not being reported immediately by the mandated Reporter is at risk of being affected. **Measures put into place to prevent recurrence.** The current Administrator conducted in-serviced education to facility staff on 7-16-2014 through 7/18/214 on all three shifts on how to identify abuse, how to report abuse, and the obligation of the mandated reporter to the reporting entities for any suspicion of resident abuse. In addition an Abuse Binder was compiled and a step-by step policy and procedure on identifying abuse, reporting and completion of the SOC-341	

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	555124	A. BUILDING _____ B. WING _____	07/14/2014

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Gridley Healthcare & Wellness Centre, LLC	246 Spruce St, Gridley, CA 95948-2216 BUTTE COUNTY

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	deceased. CNA G added that she was absolutely disgusted by the lack of respect this showed for human life and for a person who had passed. CNA G went on to explain that "our residents are mothers, fathers, sisters, brothers and are all humans that love and have feelings." CNA G stated that it was amazing to her that a person could be so uncaring for a laugh. CNA G stated that she had received abuse training in the facility. CNA G stated that this constituted abuse to residents, which was why she had reported it to the Administrator. CNA G stated that she was surprised to find out that CNA B was still scheduled to work with residents after this had been reported. On 5/14/14 at 1:30 pm, during an interview, CNA C, confirmed that while working in the facility she had received video on her cell phone through the snap-chat app of CNA B twerking (dancing to popular music in a sexually provocative manner involving thrusting hip movements and a low, squatting stance) over the head of a resident and of CNA A twerking over a recliner that was located in a resident room. CNA C stated staff frequently used the snap-chat app to communicate by texting words to each other. CNA A explained that a photo of the background was always included with the text since the snap-chat app was designed for sending real time photos and videos. CNA C stated that many times the background in the photos included partial pictures of residents. CNA C stated that the pictures and videos were sent on many occasions to multiple staff in the facility. CNA C confirmed that these incidents had not been reported. When asked why she did not report the		paperwork to assist the mandated reporter. The DSD has included this training as part of the general orientation process for new employee as well as in-service education 2x/year for staff. **Monitoring to assure sustained compliance.** The Director of Staff Development will be responsible for completing 2x a year audits of staff attendance records to assure training of staff is completed no less than twice a year. Employees will be questioned on a random schedule on all 3 shifts by the Administrator to help identify the staff knowledge of mandated abuse reporting and identification of abuse. Finding will be reported to the CQI committee monthly. Administrator is responsible for compliance.	

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	incidents, CNA C stated that the resident in the video where CNA B was twerking over his head was not identifiable from the picture and did not appear to be aware of what was happening. The resident appeared to be sleeping or unconscious. CNA C explained that now after thinking it through, she realized it should have been reported since the behavior in itself was undignified and humiliating towards the resident. On 5/1/14 at 5:15 pm during an interview, the Administrator confirmed that CNA G had informed him on 4/29/14 that CNA A had sent inappropriate pictures of residents using the snap-chat app. The Administrator stated that he had not started an investigation process or reported the incident because there was no concrete evidence that it had occurred. The Administrator confirmed that he had not spoken with CNA A. The Administrator stated that CNA A was currently clocked in and working in the facility. The Administrator confirmed that the facility's abuse prevention policy had not been followed when CNA C and other staff, did not report the alleged mistreatment of residents by CNA A and CNA B. On 7/14/14 at 4:15 pm during a telephone interview, the facility's New Administrator stated that the Department of Justice (DOJ) investigators had taken staff phones to retrieve deleted data, and were able to provide the facility with information that included which residents and CNA's were involved. The New Administrator stated the facility had fired five CNAs who had been involved.			

State of California - Health and Human Services Agency — Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 23-2498-0011221-S

Date: 03/19/2015 Time: 1605

Type of Visit :

YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE FEDERAL STATUTES AND REGULATIONS

Incident/Complaint No.(s) : CA00397188, CA00396903

Licensee Name: Gridley Healthcare & Wellness Centre, LLC

Address: 246 Spruce Street Gridley, CA 95948

License Number: 230000047 Type of Ownership: Limited Liability Company

Facility Name: Gridley Healthcare & Wellness Centre, LLC
Address: 246 Spruce St Gridley, CA 95948
Telephone: (530) 846-6266
Facility Type: Skilled Nursing Facility Capacity: 82
Facility ID: 230000041

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT $2,000.00	DEADLINE FOR COMPLIANCE 3/31/15 8:00 a.m.

1418.91(a)

CLASS B **CITATION -- PATIENT RIGHTS**

1418.91(a) Health & Safety Code: Fail to Report Alleged Abuse

(a)A long-term health care facility shall report all incidents of alleged abuse or suspected abuse of a resident of the facility to the department immediately, or within 24 hours.

The facility failed to operationalize their abuse prevention policies when incidents of abuse and mistreatment of residents were not investigated or reported to the department within 24 hours. This resulted in the offending CNAs continuing to work with residents which jeopardized resident safety and well-being.

On 5/1/14, the facility's undated policy to address abuse prevention, investigation, and reporting indicated that any allegations of abuse would be investigated immediately. The policy indicated that the purpose of the policy was to protect residents from abuse, neglect and mistreatment. The policy indicated gestured language that was derogatory or disparaging, was considered abuse, regardless of the resident's age, ability to comprehend, or disability. The policy indicated "mental abuse", included humiliation and harassment of the resident. The policy indicated that facility staff who had witnessed or who believed that a resident had been a victim of mistreatment or abuse,

Name of Evaluator:
Nancy Elloway
HFEN

Evaluator Signature : Nancy Elloway

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature : Linda R Trejino

Name : Linda R Trejino

Title : Administrator

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	must immediately report, or cause a report to be made of the mistreatment. The policy indicated that the facility staff must not knowingly fail to report an incident of mistreatment or other offense. The policy indicated that the allegation of abuse would be reported to the department of public health within 24 hours. The facility's employee handbook, dated 4/2013, indicated that the use of personal communication devices, such as cellular (cell) phones, was prohibited during normal work hours and in all work areas. On 5/5/14 at 9:30 am during an interview, CNA G explained that on 4/29/14, during the day shift, she made a report to the Administrator. CNA G reported that CNA A had been using the snap chat application (app) (enables real time photographs and video to be displayed for a few seconds on another person's cellphone, but is not saved on either device) to send pictures of residents that were inappropriately exposed and/or appeared to be deceased. CNA G added that she was absolutely disgusted by the lack of respect this showed for human life and for a person who had passed. CNA G went on to explain that "our residents are mothers, fathers, sisters, brothers and are all humans that love and have feelings." CNA G stated that it was amazing to her that a person could be so uncaring for a laugh. CNA G stated that she had received abuse training in the facility. CNA G stated that this constituted abuse to residents, which was why she had reported it to the Administrator. CNA G stated that she was surprised to find out that CNA B was still scheduled to work with residents after this had been reported. On 5/14/14 at 1:30 pm, during an interview, CNA C, confirmed that while working in the facility she had received video on her cell phone through the snap-chat app of CNA B twerking (dancing to popular music in a sexually provocative manner involving thrusting hip movements and a low, squatting stance) over the head of a resident and of CNA A twerking over a recliner that was located in a resident room. CNA C stated staff frequently used the snap-chat app to communicate by texting words to each other. CNA A explained that a photo of the background was always included with the text since the snap-chat app was designed for sending real time photos and videos. CNA C stated that many times the background in the photos included partial pictures of residents. CNA C stated that the pictures and videos were sent on many occasions to multiple staff in the facility. CNA C confirmed that these incidents had not been reported. When asked why she did not report the incidents, CNA C stated that the resident in the video where CNA B was twerking over his head was not identifiable from the picture and did not appear to be aware of what was happening. The resident appeared to be sleeping or unconscious. CNA C explained that now after thinking it through, she realized it

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	should have been reported since the behavior in itself was undignified and humiliating towards the resident. On 5/1/14 at 5:15 pm during an interview, the Administrator confirmed that CNA G had informed him on 4/29/14 that CNA A had sent inappropriate pictures of residents using the snap-chat app. The Administrator stated that he had not started an investigation process or reported the incident because there was no concrete evidence that it had occurred. The Administrator confirmed that he had not spoken with CNA A. The Administrator stated that CNA A was currently clocked in and working in the facility. The Administrator confirmed that the facility's abuse prevention policy had not been followed when CNA C and other staff, did not report the alleged mistreatment of residents by CNA A and CNA B. On 7/14/14 at 4:15 pm during a telephone interview, the facility's New Administrator stated that the Department of Justice (DOJ) investigators had taken staff phones to retrieve deleted data, and were able to provide the facility with information that included which residents and CNA's were involved. The New Administrator stated the facility had fired five CNAs who had been involved.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555124	A. BUILDING _____ B. WING _____	07/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gridley Healthcare & Wellness Centre, LLC	246 Spruce St, Gridley, CA 95948-2216 BUTTE COUNTY

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	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit: CLASS B CITATION -- PATIENT RIGHTS 23-2498-0011220-S Complaint(s): CA00397188, CA00396903 Representing the Department of Public Health: Surveyor ID # 29635, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. T22 DIV5 CH3 ART3 - 72315(b) Nursing Service - Patient Care (b) Each patient shall be treated as individual with dignity and respect and shall not be subjected to verbal or physical abuse of any kind. The facility failed to ensure an environment free from abuse and mistreatment when staff members took and sent undignified and disrespectful photographs and videos of residents. The videos included CNA B twerking (dancing to popular music in a sexually provocative manner involving thrusting hip movements and a low, squatting stance) over a resident's head and CNA A twerking in a resident's room. This resulted in abuse of residents when they were subjected to mistreatment that was undignified and humiliating.		*Gridley Healthcare and Wellness Centre submits this response and Plan of Correction as part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider or its employee, agents, officers, directors or shareholders.* *The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party.*	3/28/15

Event ID:N0GI11 3/18/2015 10:54:45AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda R Trevino | TITLE: Administrator | (X6) DATE: 3.19.15

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 4

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. Except for nursing homes, the findings 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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	On 5/1/14, the facility's undated policy to address abuse prevention, indicated that the purpose of the policy was to protect residents from abuse, neglect and mistreatment. The policy indicated gestured language that was derogatory or disparaging, was considered abuse, regardless of the resident's age, ability to comprehend, or disability. The policy indicated "mental abuse", included humiliation and harassment of the resident. The facility's employee handbook, dated 4/2013, indicated that the use of personal communication devices, such as cellular (cell) phones, was prohibited during normal work hours and in all work areas. On 5/1/14 at 1:45 pm during a telephone interview, an anonymous complainant explained that videos were sent by cellphone of Certified Nursing Assistant B (CNA B) twerking over a residents head, and a photo was sent of a resident (Resident 1), who was only wearing a brief, being carried by CNA B up over his shoulder. The anonymous complainant stated the photographs and videos were sent by CNA A using the snap-chat application (app) (enables real time photographs and video to be displayed for a few seconds on another person's cellphone, but is not saved on either device). On 5/5/14 at 9:30 am during an interview, CNA G explained that on 4/29/14, during the day shift, she made a report to the Administrator. CNA G reported that CNA A had been snap-chatting		**Corrective action for residents affected by the deficient practice.** Initially identification of residents involved were not identified. As the DOJ made their names know to the facility, SOC341 were completed and reported to the Department of Public Health and to the resident's responsible parties. Care plan were revised to observe for any symptoms of delayed reaction, and also placed on 72 hour alert charting. **Corrective action to identify other residents potentially affected by the same deficient practice and what corrective action will be taken.** Residents with unreportable abuse incidents have the potential to be affected. To help identify these residents daily room rounds are conducted by the Administrator, Director of Nursing and or	

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	photographs of residents that were inappropriately exposed and/or appeared to be deceased. CNA G added that she was absolutely disgusted by the lack of respect this showed for human life and for a person who had passed. CNA G went on to explain that, "our residents are mothers, fathers, sisters, brothers and are all humans that love and have feelings." CNA G stated that it was amazing to her that a person could be so uncaring for a laugh. CNA G stated that she had received abuse training in the facility. CNA G stated that this constituted abuse to residents, which was why she had reported it to the Administrator. CNA G stated that she was surprised to find out that CNA B was still scheduled to work with residents after this had been reported. On 5/14/14 at 1:30 pm during an interview, CNA C, confirmed that while working in the facility she had received video on her cellphone through the snap-chat app of CNA B twerking over the head of a resident and of CNA A twerking over a recliner that was located in a resident room. CNA C stated staff frequently used the snap-chat app to communicate by texting words to others. CNA A explained that a photo of the background was always included with the text since the snap-chat app was designed for sending real time photos and videos. CNA C stated that many times the background in the photos included partial photographs of residents. CNA C stated that photographs were sent, using snap-chat, on many occasions to multiple staff in the facility. CNA C stated that the resident in the video where CNA B was twerking over his head was not identifiable from the photograph and did not		managers to observe or listen for any indications or reports of allegation of abuse. **Measures put into place to prevent recurrence.** A mandatory in-service was presented to staff on Introduction of Elder Abuse, with regarding how to identifying abuse, how to report abuse by the mandated reporter and prevention of elder abuse. In-services were held for each shift in July on 16, 17, 18, 21, 22 and 23 in 2014. An abuse binder was also set up for the staff at the nurse's station. This binder provides details on how to complete, and report the SOC341 documentation. **Monitoring to assure sustained compliance.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	appear to be aware of what was happening. The resident appeared to be sleeping or unconscious. However, CNA C explained that after thinking it through, she realized the behavior in itself was undignified and humiliating towards the resident. On 7/14/14 at 4:15 pm during a telephone interview, the facility's New Administrator stated that the Department of Justice (DOJ) investigators had taken staff cell phones to retrieve deleted data, and were able to provide the facility with information that included which residents and CNAs were involved (Residents 1, 2, 3 and 4) in the abuse incidents. Resident 1 was identified as the resident being carried over the shoulder of CNA B. The New Administrator stated the facility had fired five CNAs who had been involved.		The managerial team has resident room assignments called Angel Rounds. Managers are responsible for meeting and monitoring residents in their assigned rooms. Daily rounds are made by the Administrator and Director of Nursing to observe, question, and evaluate for any reportable incidents of elder abuse. All incidents are investigated and reviewed by the IDT daily during the week, and finding are reported to the CQI committee. The Administrator is responsible for compliance.	

State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 23-2498-0011220-S

Date: 03/19/2015 Time: 1615

Type of Visit :

YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE FEDERAL STATUTES AND REGULATIONS

Incident/Complaint No.(s) : CA00397188, CA00396903

Licensee Name:	Gridley Healthcare & Wellness Centre, LLC		
Address:	246 Spruce Street Gridley, CA 95948		
License Number:	230000047	Type of Ownership:	Limited Liability Company

Facility Name:	Gridley Healthcare & Wellness Centre, LLC
Address:	246 Spruce St Gridley, CA 95948
Telephone:	(530) 846-6266
Facility Type:	Skilled Nursing Facility
Facility ID:	230000041

Capacity: 82

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT $2,000.00	DEADLINE FOR COMPLIANCE 3/31/15 8:00 a.m.

72325(b)

CLASS B **CITATION -- PATIENT RIGHTS**

T22 DIV5 CH3 ART3 - 72315(b) Nursing Service - Patient Care

(b) Each patient shall be treated as individual with dignity and respect and shall not be subjected to verbal or physical abuse of any kind.

The facility failed to ensure an environment free from abuse and mistreatment when staff members took and sent undignified and disrespectful photographs and videos of residents. The videos included CNA B twerking (dancing to popular music in a sexually provocative manner involving thrusting hip movements and a low, squatting stance) over a resident's head and CNA A twerking in a resident's room. This resulted in abuse of residents when they were subjected to mistreatment that was undignified and humiliating.

On 5/1/14, the facility's undated policy to address abuse prevention, indicated that the purpose of the policy was to protect residents from abuse, neglect and mistreatment. The policy indicated gestured language that was derogatory or disparaging, was considered abuse, regardless of the resident's age, ability to comprehend, or disability. The policy indicated "mental abuse", included humiliation and harassment of the resident.

Name of Evaluator:
Nancy Elloway
HFEN

Evaluator Signature : Nancy Elloway

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature : Linda Irwin

Name : LINDA IRWIN

Title : Administrator

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

The facility's employee handbook, dated 4/2013, indicated that the use of personal communication devices, such as cellular (cell) phones, was prohibited during normal work hours and in all work areas.

On 5/1/14 at 1:45 pm during a telephone interview, an anonymous complainant explained that videos were sent by cellphone of Certified Nursing Assistant B (CNA B) twerking over a residents head, and a photo was sent of a resident (Resident 1), who was only wearing a brief, being carried by CNA B up over his shoulder. The anonymous complainant stated the photographs and videos were sent by CNA A using the snap-chat application (app) (enables real time photographs and video to be displayed for a few seconds on another person's cellphone, but is not saved on either device).

On 5/5/14 at 9:30 am during an interview, CNA G explained that on 4/29/14, during the day shift, she made a report to the Administrator. CNA G reported that CNA A had been snap-chatting photographs of residents that were inappropriately exposed and/or appeared to be deceased. CNA G added that she was absolutely disgusted by the lack of respect this showed for human life and for a person who had passed. CNA G went on to explain that, "our residents are mothers, fathers, sisters, brothers and are all humans that love and have feelings." CNA G stated that it was amazing to her that a person could be so uncaring for a laugh. CNA G stated that she had received abuse training in the facility. CNA G stated that this constituted abuse to residents, which was why she had reported it to the Administrator. CNA G stated that she was surprised to find out that CNA B was still scheduled to work with residents after this had been reported.

On 5/14/14 at 1:30 pm during an interview, CNA C, confirmed that while working in the facility she had received video on her cellphone through the snap-chat app of CNA B twerking over the head of a resident and of CNA A twerking over a recliner that was located in a resident room. CNA C stated staff frequently used the snap-chat app to communicate by texting words to others. CNA A explained that a photo of the background was always included with the text since the snap-chat app was designed for sending real time photos and videos. CNA C stated that many times the background in the photos included partial photographs of residents. CNA C stated that photographs were sent, using snap-chat, on many occasions to multiple staff in the facility. CNA C stated that the resident in the video where CNA B was twerking over his head was not identifiable from the photograph and did not appear to be aware of what was happening. The resident appeared to be sleeping or unconscious. However, CNA C

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	explained that after thinking it through, she realized the behavior in itself was undignified and humiliating towards the resident. On 7/14/14 at 4:15 pm during a telephone interview, the facility's New Administrator stated that the Department of Justice (DOJ) investigators had taken staff cell phones to retrieve deleted data, and were able to provide the facility with information that included which residents and CNAs were involved (Residents 1, 2, 3 and 4) in the abuse incidents. Resident 1 was identified as the resident being carried over the shoulder of CNA B. The New Administrator stated the facility had fired five CNAs who had been involved.