STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0580	A. BUILDING: _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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) COMPLETE DATE
D 000	Initial Comments A state licensure complaint investigation survey was conducted from 10/23/23 through 10/26/23. Event ID# KNUD11. The following intakes were investigated NC00201396, NC00204455, NC00204469, NC00206385, NC00207936 and NC207938. Intakes NC00207936 and NC00207938 resulted in a Type A1 Violation. Three of the eight complaint allegations resulted in deficiency. A Type A1 Violation began on 9/24/23 and was removed on 10/26/23.	D 000		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on record review, observation, and interviews with staff, Responsible Party (RP), and Detective, the facility failed to protect a resident's (Resident #124) right to be free from employee to resident physical abuse, to immediately report suspected abuse to the administration, and to remove the accused employee from the floor to protect other residents from abuse. This occurred for 1 of 2 residents reviewed for abuse (Resident #124). On 09/24/2023, Patient Care Assistant (PCA) #1 pushed Resident #124 and she fell to the ground. Resident #124 was transferred to the hospital and diagnosed with a displaced left	D 338	Preparation or execution of this plan of correction does not constitute admission or agreement by Windsor point of the truth of the facts alleged or conclusions set forth in this statement of deficiency. This plan of correction is prepared and executed solely because it is required the by the Federal and State regulation. This plan of correction is submitted in order to respond to the allegation of noncompliance cited during the 10/23/2023-10/26/2023 recertification survey.	11/17/23

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D 338	Continued From page 1 femoral (part of the femur/thigh bone that forms the hip) neck fracture. Resident #124 was transferred to the hospital's inpatient hospice on 10/03/2023 with a life expectancy of days. Resident #124 died on 10/06/2023 from complications of left hip fracture. The facility also failed to protect a resident's right to privacy for 1 of 1 resident reviewed for privacy when PCA #3 videotaped Resident #13 in his incontinence brief and uploaded the video to her social media account. Resident #13 did not have the cognitive capacity to express an adverse outcome. A reasonable person would have suffered feelings of humiliation and embarrassment. The Type A1 Violation began on 9/24/23 when PCA #1 physically abused Resident #124. (A Type A1 Violation means a violation by a facility of applicable laws and regulations governing a facility which results in death or serious physical harm, abuse, neglect, or exploitation of a resident.) The Type A1 Violation was removed on 10/26/23 when the facility provided and implemented an acceptable credible allegation of Type A1 Violation removal. Example #2 (Resident #13) was cited as a Type B Violation. The findings included: Resident #124 was initially admitted to the facility on 11/04/2022 and readmitted on 01/05/2023 with diagnoses to include severe dementia with agitation and atrial fibrillation. The level of care assessment for Resident #124 dated 01/01/2023 revealed she was alert and oriented to self only and required limited assistance with activities of daily living. A physician's order dated 01/05/2023 for Resident	D 338	Type A1 Violation Resident #124 was discharged from the facility on 09/25/2023. No other residents were injured in the memory care unit. All of the memory care residents were assessed head to toe for any injuries on 09/25/2023 by the Assisted Living Supervisor. PCA #1 was only assigned to one hall of the memory care unit with a total census of 14. She did not work in any other area of Windsor Point. PCA #1 last worked on 09/25/2023. PCA #1 was terminated on 09/25/2023. All residents were at risk to be affected by not having their rights guaranteed and maintained without hindrance. PCA #1 was terminated. Abuse Training, abuse retraining, abuse education and abuse reeducation will continue throughout staff employment and will begin with new employee orientation. Two staff members are required in the memory care unit as of 9/25/2023 despite the census. The Administrator will continue to review staff assignment sheets to ensure proper staff coverage in the memory care unit daily beginning on 9/25/2023. 100% of Assisted Living staff were educated on Abuse to include an update to the reporting procedure on 10/25/2023 by the Administrator and the Assisted Living Supervisor. The Medication Aide is now responsible for completing the initial	

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D 338	Continued From page 2 #124 revealed she was receiving Eliquis (a blood thinner) 2.5 milligram (mg) tablet by mouth twice a day for atrial fibrillation. The initial Psychiatry visit report for Resident #124 dated 07/25/2023 revealed she was severely cognitively impaired and was physically aggressive at times. A telephone interview was conducted with Nurse #1 on 10/24/2023 at 4:54 PM. Nurse #1 stated that he was working on the skilled unit on 09/24/2023, when he received a call from the memory care unit (assisted living) around 11:00 PM. He reported that when he entered the locked memory care unit he found Resident #124 lying on the floor and screaming that she was in pain. Nurse #1 indicated that there appeared to be shortening to Resident #124's left leg and she had a skin tear on her left elbow. He stated that he tried to obtain vital signs but Resident #124 was screaming and would not allow him to touch her. Nurse #1 further stated that his focus had been on Resident #124 and staying with her until Emergency Medical Services (EMS) arrived. He stated that he was not made aware by any of the staff of a concern that Resident #124 had been abused by PCA #1. A triage note written by Nurse #1 to the on-call Nurse Practitioner on 09/25/2023 with a faxed time of 12:22 AM, revealed he was called to the memory care unit after Resident #124 had an unobserved fall (09/24/2023). Nurse #1 sent Resident #124 to the hospital for possible left hip and pelvic fractures. The telephone notification to the on-call Nurse Practitioner was listed as 09/24/2023 at 11:20 PM. The hospital record indicated Resident #124 was	D 338	allegation report to be faxed to the Health Care Personnel Registry after reporting the abuse to the Administrator as soon as abuse is confirmed or suspected. The Medication Aide is to contact Security to have any staff member suspected of abuse removed from the floor. The update was completed on 10/25/2023 by the Administrator. All of the Assisted Living staff acknowledged the resident's right to be free from abuse as of 10/25/2023 prior to being able to work with the residents. This requirement is continuously tracked by the Supervisor in Charge of Assisted Living. The Administrator will continue to be responsible for completing the investigation report after completing the internal investigation. All Assisted Living Medication Aides were educated by the Administrator on how to complete the initial allegation report on 10/25/2023. Assisted Living staff were educated by the Administrator on how to manage residents with dementia/cognitive loss as well as residents with difficult/challenging behaviors on 10/25/2023. Common Behavioral Manifestations of Dementia were discussed as well as assumptions about dementia to include unpredictability. Principles of Behavior Management were discussed to include staff responsibilities. 100% of the Assisted Living staff were educated by the Administrator on the importance of reporting allegations of abuse and/or suspected abuse to the administrator and for any accused staff to	

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D 338	Continued From page 3 admitted on 09/24/2023 at 11:39 PM following a witnessed fall resulting in severe left hip pain. A computed tomography (CT) scan revealed an acute displaced proximal, left femoral neck fracture. The facility incident report indicated the Administrator first became aware of the incident on 09/25/2023 at 11:35 AM. The report further indicated the nature of the event to be suspected abuse for an observed fall during ambulation that occurred on 09/24/2023 at 11:02 PM on the memory care unit. The contributing factor was listed as staff related. The report further listed the sites of injury as left upper arm, right upper arm, left lower arm, left hip, and left shoulder. The report listed Resident #124's condition was supervised, and she was alert and upset. The intervention the facility provided was Resident #124 was sent to the hospital. There were 3 witness statements attached to the incident report (PCA #1, PCA #2, and Medication Aide (MA) #1). The witness statement written by PCA #1 on 09/25/2023 read in part, "Did you see the accident happen?" The yes box was marked with a check mark. PCA #1's description of the incident read in part, " I was sitting down, and Resident #124 was up and talking about how she wanted to go home, and I told her she was already home. She kept talking and I got up and she was moving, and she must have tripped, I don't know, but she fell and hit the floor. I don't want anybody thinking that I had anything to do with that. [MA #1] was not back there at all. I was on the hall by myself, and she was supposed to be back there." Multiple attempts were made to contact PCA #1 by telephone on 10/24/2023 and the message on	D 338	be removed from the floor immediately. The education was completed on 10/25/2023. Assisted Living employees will be tracked for completion of the Abuse training updates prior to being scheduled to work by the Assisted Living Supervisor. Staff will continue to be trained, retrained, educated and reeducated on how to report abuse. Nurse consultant/designee will randomly interview staff as to what they would do if they saw a resident being abused and/or saw any signs of abuse. These random interviews will serve as audits to occur 3 times per week for 30 days, then 2 times per week for 30 days, then 1 time per week for 30 days. The results of these audits will be reported to the Administrator immediately for correction then presented to the QAPI committee for 3 months in order to identify trends and to establish recommendations for improvement. Type B Violation Resident #13 was assessed for any negative effects related to the 8/17/23 incident that resulted in a video that was posted to PCA #3 social media account. No other residents were affected by the 8/17/23 incident involving a staff member social media account. PCA #3 was terminated on 8/17/23. Staff retraining was initiated on 8/17/23 to address HIPAA in regard to privacy and maintaining confidentiality with a focus on	

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D 338	Continued From page 4 the phone stated she was unavailable. The witness statement written by MA #1 on 09/25/2023 read in part, "Did you see the accident happen?" The yes box was marked with an X. It further read, "I was in the process of entering Hayes Hall [memory care unit] after standing outside listening to [Resident #124] yelling and fussing and all of a sudden, the resident appeared and was in motion of falling on left side in the commons area of Hayes Hall." MA #1 listed the names of the witnesses as PCA #1 who was listed as present with the resident and PCA #2 who entered the doors behind her. MA#1 indicated Resident #124 was very upset and screaming she was in pain. An attempt was made to contact MA #1 on 10/24/2023 by telephone and her phone number was disconnected or no longer in service. An interview was completed with the Administrator on 10/24/2023 at 10:38 AM. The Administrator stated that MA #1 was employed by the facility until 10/23/2023 when she did not call and did not show up for work. The witness statement written by PCA #2 on 09/25/2023 read in part, "Did you see the accident happen?" The no box was checked. PCA #2's description of the incident read in part, "I heard someone yelling help me and it was coming from Hayes Hall. When I entered the hall, I saw [Resident #124] lying on the floor in severe pain. Before opening the door, I heard the conversation between [Resident #124] and [PCA #1]. [PCA #1] made the statement to [Resident #124] "do not walk up on me." A telephone interview was conducted with PCA	D 338	resident rights, privacy, dignity, the cell phone policy and reporting requirements for any privacy violations. Resident privacy audits will be conducted 5 times per week for 30 days then monthly to identify any potential concerns related to HIPAA violations. The results of the audit will be presented to the QAPI committee to determine compliance and resolution.	

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#2 on 10/24/2023 at 5:16 PM. PCA #2 stated that she was working on the assisted living hall adjacent to the memory care unit, talking to MA #1 on 09/24/2023 around 11:00 PM. She further stated that they heard someone yelling and it sounded like it was coming from the memory care unit. PCA #2 indicated that MA #1 got to the locked door before she did and when she entered Resident #124 was lying on the floor. She stated that PCA #1 was yelling at Resident #124, "this would not have happened if you had gone to bed." PCA #2 further stated that Resident #124 was yelling and pointing at PCA #1 "She did it! She hit me! That [expletive] pushed me!" She indicated that she was frequently assigned to care for Resident #124, and she could be aggressive at times, but that she was easily redirected by walking with her or talking to her. PCA #2 stated that Resident #124 was able to ambulate independently. PCA #2 further stated that they did not move Resident #124 and waited with her until EMS arrived. PCA #2 further stated that she had not witnessed PCA #1 push Resident #124 or seen the fall. She indicated that MA #1 instructed her to stay with Resident #124 and PCA #1 while she notified the family and the physician. PCA #2 stated MA #1 asked her to stay on the memory care unit so PCA #1 would not be alone with the other residents. She did not explain why MA #1 had not wanted PCA #1 to be alone with the other residents. She revealed there were times she left PCA #1 alone on the unit to take a break. PCA #2 indicated she had not reported anything to the Administrator because she did not see the fall and Resident #124 was confused.

An observation of the memory care unit where the incident took place occurred on 10/24/2023 at 4:25 PM with the Administrator. The memory care unit was a locked unit with double doors that had

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windows in them. A keypad to enter the code to get into the unit was located on the wall outside the door. The
Administrator stated that the incident took place in the hall outside of the common area located on the left side of the entry doors to the memory care unit. She explained that there were two video cameras that were located on the wall next to the doors facing the hallway. The Administrator stated that the video showed Resident #124 in the hallway pacing and yelling in front of the doorway to the common area. She further stated that PCA #1 was yelling at Resident #124, and then suddenly Resident #124 fell sideways and landed on her left side. The Administrator indicated that only Resident #124 was visible on the camera, because PCA #1 was standing in the doorway to the common area. She further stated that the video did not explicitly show PCA #1 push Resident #124 but that they were able to see that something happened to make her fall.

The hospital record indicated on 9/25/23, Resident #124 had an open treatment of the left femoral fracture, proximal end, neck with prosthetic replacement (cemented bipolar hip surgery). A clinical note written by the Physician Assistant (PA) on 9/29/2023 at 2:18 PM read in part, "the patient has continued to decline and refuse all PO [oral] intake since 09/24/2023." It further read, "significant decline since surgery. This was likely her tipping event. Family is requesting hospice/comfort care." Resident #124 was transferred to the hospital inpatient hospice on 10/3/23 with a life expectancy of days.

A telephone interview with Resident #124's RP was completed on 10/23/2023 at 12:10 PM. The RP stated Resident #124 passed away on 10/06/2023 at inpatient hospice.

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D 338	Continued From page 7 The Death Certificate for Resident #124 signed by the Medical Examiner on 10/16/2023 revealed she died on 10/06/2023 from complications of left hip fracture. A news article from a local station (WRAL News) dated 10/25/23 indicated PCA #1 was arrested on 10/24/23 and charged with the murder of Resident #124. The article indicated the incident was on surveillance video. The Police Captain was quoted in the article stating Resident #124 "hits the ground and you see [PCA #1] clearly push her." The Police Incident/Investigation report related to staff to resident abuse involving PCA #1 and Resident #124 was provided to the State Agency on 10/27/23 but due to it being an ongoing investigation the information contained in the report was not for public view and therefore could not be included in the citation. A telephone interview was conducted with the Detective in charge of the investigation on 10/26/2023 at 9:08 AM. The Detective stated that PCA #1 was arrested on murder charges related to the incident that occurred on 09/24/2023 at 11:02 PM with Resident #124. He stated that the medical examiner and the district attorney had decided on the charges. The Detective stated that since it was an ongoing investigation that he could not release further information or the surveillance video. An interview was conducted with the Administrator on 10/24/2023 at 4:18 PM. The Administrator stated that when she arrived to work on 09/25/2023 around 7:00 AM she was informed by a staff member that Resident #124	D 338		

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had fallen on 09/24/2023 around 11:00 PM and she had been sent to the hospital for a possible hip fracture. The Administrator indicated that she overheard MA #1 speaking loudly to PCA #1 that morning (09/25/2023) stating that she knew she pushed Resident #124, and it was her fault that she fell. The Administrator stated that she immediately began her investigation and got witness statements from PCA #1, MA #1, and PCA #2. She reported that she called security and asked to see the video of the incident. The Administrator indicated that she watched the video, and it was apparent that PCA #1 had done something to make Resident #124 fall. She stated that the video only had Resident #124 on the camera but the way she fell was awkward, and hard, landing on her left side and hip. The Administrator revealed that PCA #1 had continued to work the rest of the night until 7:00 AM on the memory care unit. The Administrator stated that PCA #1 did it, she caused Resident #124 to fall. She stated that in 30 years of being in healthcare and a Social Worker and Administrator, she had never seen anything like that video. She indicated that she then called the police, and they came to the facility around 1:00 PM on 09/25/2023, and they watched the video. The Administrator stated that the police arrested PCA #1 on facility property. She explained that PCA #1 was still at the facility at that time in a room she allowed staff to sleep in if they worked over or lived too far away to drive home. She further stated that PCA #2 and MA #1 should have reported the suspected abuse immediately to her and PCA #1 should not have been allowed to continue working with residents. The Administrator indicated that PCA #1 was terminated on 09/25/2023 and the facility had obtained a no trespass order against her on that date. She stated that she had faxed the initial

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report to the state on 09/25/2023 at 7:22 PM. The Administrator revealed that after Resident #124 died on 10/06/2023, the police officers came back to the facility with a search warrant and confiscated a flash drive of the video, and PCA #1's personnel file. She stated that the facility did not have a copy of the video and that the video was recorded over every two weeks. She indicated the police had reinterviewed staff members when they were at the facility. The Administrator stated that she had never had any other reports of suspected abuse by PCA #1, and she did not know what had caused her to snap that night.

The Administrator was notified of the Type A1 Violation on 10/25/2023 at 11:57 AM.

The facility provided the following credible allegation of Type A1 Violation removal.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

Resident #124 was not protected from abuse by PCA #1 on 09/24/2023.

PCA #2 suspected abuse and witnessed the resident alleged abuse by PCA #1 and did not immediately report to administration which in turn allowed PCA #1 to finish working her shift with other residents.

No other residents were injured in the memory care unit. All the memory care residents were assessed for any injuries on 09/25/2023 by the Assisted Living Supervisor. PCA #1 was only assigned to the memory care unit with a census of 14.

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D 338	Continued From page 10 PCA #1 last worked on 09/25/2023. PCA #1 was terminated on 09/25/2023. PCA #1 was arrested on 09/25/2023. Administrator was notified of the suspected abuse on 09/25/2023 at 11:35am. The police were contacted on 09/25/2023 at 1:00pm. Adult Protective Service was notified on 09/25/2023 at 2:00pm. The initial allegation report was completed on 9/25/2023 and faxed to the state at 7:22pm. The investigation report was completed on 9/26/2023 and faxed to the state at 10:30am. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. Two staff members will be required in the memory care unit as of 9/25/2023 despite the census. The Administrator will review staff assignment sheets to ensure proper staff coverage in the memory care unit daily beginning on 9/25/2023. 100% of Assisted Living staff were educated on Abuse to include an update to the reporting procedure on 10/25/2023 by the Administrator and the Assisted Living Supervisor. The Medication Aide is now responsible for completing the initial allegation report to be faxed to the Health Care Personnel Registry after reporting the abuse to the Administrator as soon as abuse is confirmed or suspected. The Medication Aide is to contact Security to have any staff member suspected of abuse removed from the floor. The update was completed on 10/25/2023 by the Administrator. All the Assisted	D 338		

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WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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) COMPLETE DATE
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Living staff will acknowledge the resident's right to be free from abuse as of 10/25/2023 prior to being able to work with the residents. This requirement is being tracked by the Supervisor in Charge of Assisted Living.

The Administrator will continue to be responsible for completing the investigation report after completing the internal investigation. All Assisted Living Medication Aides will be educated by the Administrator on how to complete the initial allegation report on 10/25/2023.

Assisted Living staff were educated by the Administrator on how to manage residents with dementia/cognitive loss as well as residents with difficult/challenging behaviors on 10/25/2023. Common Behavioral Manifestations of Dementia were discussed as well as assumptions about dementia to include unpredictability. Principles of Behavior Management were discussed to include staff responsibilities.

100% of the Assisted Living staff were educated by the Administrator on the importance of reporting allegations of abuse and/or suspected abuse to the administrator and for any accused staff to be removed from the floor immediately. The education was completed on 10/25/2023. Assisted Living employees will be tracked for completion of the Abuse training updates prior to being scheduled to work by the Assisted Living Supervisor.

Alleged Completion Date: 10/26/23.

The credible allegation was validated by onsite verification on 10/26/2023 as evidenced by interviews with nursing, housekeeping, and management staff in the assisted living facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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and verification of the inservice signature sheets. All staff had been inserviced on the Abuse Policy and reporting and preventing abuse. In multiple interviews with staff members, they verified the types of abuse and that it should be reported immediately to their supervisor and the Administrator. Assisted living staff verified in interviews that they had been provided training for managing residents with dementia/cognitive loss and difficult/challenging behaviors. Medication Aides were inserviced on how to fill out the initial allegation report by the Assisted Living Supervisor. The facility's credible allegation plan with a completion date of 10/26/23 was validated.

Example #2 - Type B Violation:

2. Resident #13 was admitted into the facility on 4/14/23 with a diagnosis of Alzheimer's disease and is severely cognitively impaired.

According to facility 5-day report, on 8/17/23 the Owner was made aware that a Patient Care Assistant (PCA) #3 had videotaped Resident #13 in his incontinence brief and uploaded the video to her social media account. Records indicated that the Owner met with the facility Administrator and informed her of the video. The Administrator was unable to determine who the resident in the video was and showed the video to the Supervisor of the Dementia Unit. The Supervisor was able to determine the resident in the video was Resident #13. The Administrator then met with PCA #3 who admitted to recording and posting a video of Resident #13 in his incontinence brief. After the Administrator viewed the video on the PCA #3's phone the video was removed from PCA #3's social media account

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and the video was deleted from the phone, then PCA #3 was then terminated from employment.

An interview with PCA #3 was attempted, however, her phone number was no longer in service.

An interview with the Supervisor of the Dementia Unit was conducted on 10/25/23 at 2:00 PM who revealed that the Administrator had shown her a video taken by PCA #3 for identification of the resident in the video. She further revealed that at the time there were only 3 men in the unit, so it was very easy to determine who the resident was.

An interview was conducted with the Administrator on 10/24/23 at 4:10 PM who stated the resident in the video did not have his face or head in the video, so she had the Supervisor of the Dementia Unit view the video for identification of the resident. The Administrator then met with PCA #3 who admitted videotaping Resident #13 and posting the video to her social media account. The Administrator revealed that PCA #3 did not seem to understand that videotaping a resident was against facility policy and was not endorsed by the family, resident, or management of the facility. The Administrator revealed she had asked PCA #3 for a written statement which she refused to do so stating, she had already admitted that she had videotaped Resident #13 she did not need to write it down. PCA #3 was then terminated from employment. She also indicated that the resident's representative was not notified of the incident. However, an initial report was sent on 8/17/23 and final investigation report dated 8/22/23 was sent to the Department of Health and Human Services (DHHS). The Administrator further revealed that law enforcement was not informed of the incident

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D 338	Continued From page 14 however Adult Protective Services was notified of the incident. The facility was notified of the Type B Violation and provided the following plan on how the violation would be removed in order to protect residents from further risk or additional harm. The Administrator ensured the video was removed from PCA #3's social media account and the video was deleted from the phone. The Administrator ensured there were no further pictures or videotapes of residents on PCA #3's phone. PCA #3 was terminated from employment. Adult Protective Services were notified and the initial and investigation report were submitted to DHHS. The facility in-service records indicated that the facility had an in-service on 8/17/23 with all employees which educated them on Health Insurance Portability and Accountability Act (HIPPA) what effect it has on you? What is it? And HIPPA privacy and maintaining confidentiality.	D 338		