

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

PRINTED: 05/03/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345389	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/28/2011
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF FOREST GLENN			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529	
(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
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to follow their facility's employee handbook policy regarding confidentiality/dignity by taking a photograph of a resident without his/her permission/authorization to 1 (Resident #1) of 3 sampled residents. The finding includes:</p> <p>The facility's employee handbook was reviewed. The handbook policy read in part " Disclosing confidential information concerning employees, residents or the facility ". This includes " taking photographs of residents without permission or authorization and the use of video/picture telephones within the facility or facility grounds ".</p> <p>Resident #1 was originally admitted to the facility on 06/01/09 with multiple diagnoses including Hypertension, Diabetes Mellitus, End Stage Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF) and Psychosis. The current Minimum Data Set (MDS) assessment dated 02/21/11 revealed that the resident had moderately impaired cognition.</p> <p>On 04/28/11 at 8:25 AM, Resident #1 was interviewed. The resident stated that she was in the toilet when a nursing assistant took a picture of her. She further stated that she did not know</p>	F 241	<p>The Laurels of Forest Glenn wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is 05/06/2011.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.</p> <p>F241 Resident #1 had a photograph taken of her without permission. The facility Administrator had done a thorough investigation and appropriate disciplinary action had been taken.</p> <p>All residents may potentially be affected by these practices. Administrator/designee will in-service staff on the policy regarding the usage of video/picture telephones within the facility or on facility grounds.</p> <p>The facility's policy regarding the usage of video/picture telephones within the facility or on facility grounds has been reviewed and no changes are warranted at this time.</p>	5/6/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Administrator

5/6/11

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 241	<p>Continued From page 1</p> <p>the name of the nursing assistant but she knew her by face. She also stated that it happened in the afternoon but did not remember the exact date and time. When asked how she feels about it, the answer was irrelevant.</p> <p>On 04/28/11 at 8:40 AM, NA #1 (nursing assistant #1) was interviewed. She stated that she heard that a nursing assistant was fired two weeks ago for taking picture of the resident who was naked in the bathroom. She further stated that the alleged nursing assistant denied the allegation but three other nursing assistants had seen the picture.</p> <p>The administrative staff #1 was interviewed on 04/28/11 at 9:05 AM. The administrative staff #1 stated that the incident regarding Resident #1 happened on 04/17/11 (time unknown), was reported on 04/18/11 and was investigated. The alleged employee (NA #2) was terminated on 04/18/11. The administrative staff indicated that he treated the allegation as a dignity issue.</p> <p>The investigation report was reviewed. The allegation indicated that on 04/17/11 (no time), NA # 2 (assigned to the resident) took picture of Resident #1 with no clothes on and was showing the picture to employees on 100 and 200 halls, thinking that it was funny. NA #2 took the picture using her phone camera. The administrator spoke to NA #2 who denied the allegation. The report had written statements from three nursing assistants (NAs #3, #4, & #5) who confirmed that they had seen the picture of Resident #1 sitting on the commode naked. The written statement from NA #3 read " (name of NA #2) showed me a picture of a resident exposed naked on the toilet</p>	F 241	<p>Administrator/designee is responsible for compliance. Administrator/designee will audit for dignity/cell-phone use during facility rounds weekly for the next (4) four weeks to ensure privacy and dignity is maintained. Variances will be corrected at the time of observation. Monitoring results will be reported to the Director of Nursing and to the Quality Assurance committee during the monthly meeting.</p>	

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F 241	Continued From page 2 on the day of April 17, 2011 ". The written statement from NA #4 read " I was shown a picture of (name of Resident #1) naked on the toilet on (name of NA #2) cell phone ". The written statement from NA #5 read " I saw a picture of (name of Resident #1) naked on 04/17/11 on second shift "	F 241			
	<p>On 04/28/11 at 10:20 AM, NA #3 was interviewed. She stated that she was in the break room with NA #2 on 04/18/11 at dinner time. NA #2 showed her the picture of Resident #1 naked sitting on the toilet. She did not comment after seeing the picture but NA #2 thought it was funny. She further stated that she reported it the next day but the administration was already aware about it.</p> <p>On 04/28/11 at 10:43 AM, NA #4 was interviewed. She stated that after dinner time of 04/17/11, NA #2 went to her hall and showed her the picture of Resident #1 who was sitting on the toilet naked. She further stated that NA #2 used her cell phone camera to take the picture. She indicated that she was shocked after seeing the picture but did not say anything. She stated that NA #2 thought that the picture was funny.</p> <p>NA #2 and NA #5 were not available for interview.</p> <p>On 04/28/11 at 10:45 AM, administrative staff #1 was interviewed. He stated that he was made aware of the incident on 04/18/11. He investigated the incident and fired the alleged employee. He also indicated that he had not in-serviced all the staff regarding confidentiality/dignity after the incident on 04/17/11 but had talked to three nurses and the</p>				

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F 241	Continued From page 3 involved nursing assistants regarding confidentiality/dignity but did not document. He also indicated that the in-service training is always scheduled during pay days so everybody could attend. On 04/28/11 at 11:06 AM, administrative staff #2 was interviewed. She stated that the policy on the employee handbook stated that no cell phones on the resident's care areas and taking pictures of residents without her/his permission is not permitted. She also stated that the last in-service training regarding no cell phones on the resident's care areas was conducted on 04/14/11 and NA #2 had attended the in-service. She also indicated that on 03/17/11, an in-service on social media policy which includes compliance with the employee handbook focused on confidentiality and dignity was conducted. The administrative staff #2 has no record of any in-service training conducted to all staff regarding confidentiality/dignity after the incident on 04/17/11.	F 241			