STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092229	A. BUILDING: _____ B. WING _____	R 01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VAL'S PLACE AT BROOKHAVEN	6112 WINTHROP DRIVE RALEIGH, NC 27612

(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
{C 000}	Initial Comments The Adult Care Licensure Section conducted a follow- up survey on 01/10/23.	{C 000}		
{C 911}	G.S 131D 21(1) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: (1) To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 2 of 3 sampled residents (#1 and #2) were treated with consideration and right to privacy related to a video/audio monitor of the residents that was placed in the kitchen on the countertop allowing visitors and other residents to observe the residents in their rooms. The findings are: Observations of the facility on 01/10/23 between 9:23am and 9:39am revealed: There were 2 facility staff on duty. -There were 3 video/audio monitors in the kitchen on the countertop with the camera view facing outward towards the open kitchen area. -The 3 video/audio monitors were labeled with Resident #1's, Resident #2's and Resident #3's names. -2 of the 3 video/ audio monitors were actively on, labeled Resident #1 and Resident #2. a. Review of Resident #1's current FL-2 dated 07/6/22 revealed: -Diagnoses included depression, hypertension, hyperthyroid, hyperlipidemia and osteoporosis.	{C 911}		

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{C 911}	Continued From page 1 -The resident was admitted on 07/21/21. Observations of the facility on 01/10/23 between 9:23am and 9:39am revealed the video/camera monitored for Resident # 1 revealed the facility staff putting a brief on Resident #1 and getting her dressed. Interview with Resident #1 on 01/10/23 at 9:44am revealed: -Her family member wanted the video/audio monitor in her room for safety purposes. -She was not aware the video/audio monitor was visible to everyone in the kitchen, and she did not like it. b. Review of Resident #2's current FL-2 dated 10/26/22 revealed: -Diagnoses included depression, hypertension, and dementia with behaviors. -The resident was admitted 11/03/22. Observations of the facility on 01/10/23 between 9:23am and 9:39am revealed the video/camera monitored for Resident #2 revealed the facility staff changed the resident's brief while she was lying in bed and transferring her to a chair. Interview with the Medication Aide (MA) on 01/10/23 at 10:12am revealed: -The video/audio monitors were to be turned around and not visible during the day shift. -She turned the video/audio monitors around while she was on duty to provide privacy for the residents. -She expected the video/audio monitors to be turned around during the day shift because the facility was fully staffed, and visitors were coming in and out of the facility.	{C 911}		

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{C 911}	Continued From page 2 Interview with the Administrator on 01/10/23 at 9:30am revealed: -She installed the video/audio monitors for the safety of the residents. -She did not think other people who came into the facility watched the video/audio monitors. -She did not think the resident's were being exposed because the video/audio monitors were visible to visitors. -She did not have another location to place the video/audio monitors to prevent them from being visible to visitors and other non-facility staff. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.	{C 911}		