Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Deer Crest
470 Fairview Boulevard
Red Wing, MN 55066
Goodhue County

Report #: HL25182001
Date: April 17, 2013

Date of Visit: April 1, 2013
Time of Visit: 8:50 a.m.-3:04 p.m.

By: Suzette Miller, R.N., Special Investigator

Type of Facility: □ Nursing Home □ HHA □ Home Care Provider/Assisted Living
□ SLF □ ICF/IID □ Home Care
□ Hospital □ Other: _____________

□ Facility Self Report □ Complaint

Allegation(s): It is alleged that a violation of client rights occurred when a staff person put a photo of a client sitting on a toilet on Instagram on the internet.

An unannounced visit was made at this facility and an investigation was conducted under:

- Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
- Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
- Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
- Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
- Federal Regulations for EMTALA (42 CFR Part 489)
- State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
- State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
Conclusion:

It was determined that a staff person violated the client’s right to be treated with courtesy and respect, when the staff person took a photograph of the client sitting on the toilet in the client’s bathroom, without the client’s knowledge. Evidence showed this photograph was posted on Instagram (an online photo-sharing and social networking service that enables users to take pictures via a cellular camera device and share the picture on a public social media site).

Record review and interviews established that the client displayed some memory problems and had a history of vision and hearing impairments. The client received assistance with toileting services via one staff person in the client’s apartment.

The client was interviewed and exhibited no knowledge of this incident.

During the onsite investigation, the facility provided the investigator with a copy of the photograph and a facility administrative staff person identified the client and staff person in this photograph. The client was sitting on the toilet; the client’s head was in a downward position and not facing the direction of the camera. This photograph revealed the client’s bare skin to the upper leg/hip area, lower leg and foot. Staff interviews revealed no staff witnesses to this incident.

An interview with a facility administrative staff person and review of the facility documentation showed a non-employee of the facility reported seeing this photograph on Instagram.

Review of the facility’s documentation revealed the staff person admitted to taking the photograph. The staff person was immediately suspended pending the facility’s internal investigation and was terminated upon completion of the facility’s internal investigation. The facility directed the staff person to remove the photograph from her cellular phone/camera device and any social media site.

Evidence showed the staff person received training, prior to this incident, regarding client rights and also received an employee handbook that included the facility’s policies on use of social media and cell phone use (which indicated that photographing a client with a cell phone is strictly prohibited).

Compliance:

State Licensing Rules for Home Care (MN Rules Chapter 4668) – Compliance Met
The facility was found to be in compliance with State Licensing Rules for Home Care (MN Rules Chapter 4668). No state licensing orders were issued.

**Facility Corrective Action:**

The facility took the following corrective action(s):
The facility provided written reminders to all staff regarding the facility’s policies and procedures related to this incident and reminded staff this incident is an example of a violation of client rights. Observations and interviews during the onsite investigation revealed that facility staff understood the client’s right to be treated with courtesy and respect; additionally, staff understood the facility’s policies regarding taking a client’s photograph, use of social media and cell phone use. Staff interviews showed licensed nurses and supervisors monitored staff for cell phone and camera use to prevent reoccurrences of similar incidences. There was no evidence of additional occurrences of incidences of this nature. As a result, no licensing orders were issued.

**Definitions:**

**The Investigation included the following:**

**Document Review: The following records were reviewed during the investigation:**

- Medical Records
- Care Guide
- Medication Administration Records
- Treatment Sheets
- Facility Incident Reports
- Physician Progress Notes
- ADL (Activities of Daily Living) Flow Sheets
- Laboratory and X-ray Reports
- Physician Orders
- Social Service Notes
- Nurses Notes
- Meal Intake Records
- Activities Reports
- Weight Records
- Therapy and/or Ancillary Services Records
- Assessments
- Skin Assessments
- Care Plan Records
Other pertinent medical records:

☐ Hospital Records   ☐ Ambulance/Paramedics   ☐ Medical Examiner Records   ☐ Death Certificate

☐ Police Report

Additional facility records:

☐ Resident/Family Council Minutes
☐ Staff Time Sheets, Schedules, etc.
☐ Facility Internal Investigation Reports

☐ Call Light Audits
☐ Personnel Records/Background Check, etc.
☐ Facility In-service Records
☐ Facility Policies and Procedures
☐ Other, specify: Service Plan Agreement and supervisory visit notes

Number of additional resident(s) reviewed: 0

Were residents selected based on the allegation(s)? ☐ Yes ☐ No ☐ N/A Specify: __________

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?
☐ Yes ☐ No ☐ N/A Specify: __________

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ☐ Yes ☐ No ☐ N/A Specify: Anonymous

If unable to contact complainant, attempts were made on:
Date/time: ______  Date/time: ______  Date/time: ______

Interview with family: ☐ Yes ☐ No ☐ N/A Specify: __________

Did you interview the resident(s) identified in allegation: ☐ Yes ☐ No ☐ N/A Specify: __________

Did you interview additional residents: ☐ Yes ☐ No

Total number of resident interviews: 4
Interview with staff:  ☑ Yes  ☐ No  ☐ N/A  Specify: __________

Tenessen Warning given as required:  ☑ Yes  ☐ No

Total number of staff interviews:  6

Physician interviewed:  ☐ Yes  ☑ No

Nurse Practitioner interviewed:  ☑ Yes  ☑ No

Interview with Alleged Perpetrator(s):  ☑ Yes  ☐ No  ☐ N/A  Specify: __________

Attempts to contact:  Date/time: ____  Date/time: ____  Date/time: ____

If unable to contact was subpoena issued:  ☑ Yes  , date subpoena was issued _________  ☑ No

Were contacts made with any of the following:
☐ Emergency personnel  ☐ Police Officers  ☐ Medical Examiner  ☐ Other: Specify _________

Observations were conducted related to:

☐ Wound Care  ☐ Medication Pass  ☐ Meals

☑ Personal Care  ☑ Dignity/Privacy Issues  ☐ Restorative Care

☐ Nursing Services  ☑ Safety Issues  ☑ Facility Tour

☑ Infection Control  ☐ Cleanliness  ☐ Injury

☑ Use of Equipment  ☑ Transfers  ☐ Incontinence

☑ Call Light  ☐ Other: _________

Was any involved equipment inspected:  ☑ Yes  ☐ No  ☐ N/A

Was equipment being operated in safe manner:  ☑ Yes  ☐ No  ☐ N/A

Were photographs taken:  ☑ Yes  ☑ No  Specify: _________

xc: Division of Compliance Monitoring - Licensing & Certification
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<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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A complaint investigation was initiated on April 1, 2013 to investigate complaint # HL25182001. No licensing orders are issued.