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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345547	A. BUILDING ______ B. WING ______	C **02/11/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN PLACE HEALTH AND REHAB, LLC	**1 MARITHE COURT GREENSBORO, NC 27407**

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 2/11/15. Event ID# SE8P11.	F 000		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 2 medication errors out of 26 opportunities, resulting in a medication error rate of 7.6%, for 1 of 5 residents (Resident #28) observed during medication pass. The findings included: 1) Resident #28 was admitted to the facility on 10/1/14 with diagnoses including hypertension (high blood pressure) and glaucoma (a disorder that is associated with increased fluid pressure in the eye). On 2/10/15 at 4:47 PM, Nurse #1 was observed as she prepared and administered medications to Resident #28. The administered medications included one-half (1/2) of a 25 milligram (mg) metoprolol tartrate tablet, which provided a dose of 12.5 mg metoprolol tartrate given by mouth. Metoprolol tartrate is an anti-hypertensive medication.	F 332	Facility pharmacy consultant brought the medication from the back up pharmacy and it was administered as ordered. The nurse administered 2 metoprolol tartrate after speaking with surveyor. Medication reviews were conducted by nursing supervisors for all residents. All residents have the potential to be affected. (completed 3/2/15) All medication nurses were re-educated by SDC and Supervisors thru 3/2/15 regarding: " Use of the Omnicell and back up pharmacy if medications not available " Deadline for faxing refill orders vs new admission orders. " 6 Rights of Medication Administration and comparing MAR to medication label " Returning meds to pharmacy " Faxing all order changes. " Pharmacy schedule placed in MAR. " List of medications in Omnicell placed in each MAR. QA nurse to randomly audit 10% of	3/2/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 02/27/2015

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 332	Continued From page 1 A review of Resident #28 ' s physician orders included an order dated 2/6/15 to increase the dose of metoprolol tartrate from 12.5 mg to 25 mg given by mouth twice daily. A review of the February 2015 Medication Administration Record (MAR) revealed the increased dose of 25 mg metoprolol tartrate given twice daily was initiated on 2/6/15 beginning with the 5:00 PM medication administration. An interview was conducted with Nurse #1 on 2/10/15 at 5:16 PM. During the interview, the nurse stated that she was unaware of the dose increase for Resident #28's metoprolol tartrate. A review of the metoprolol tartrate tablets packaged for Resident #28 confirmed that each bubble pack of the medication contained 1/2 of a 25 mg metoprolol tartrate tablet. The pharmacy labeling indicated that each 1/2 tablet equaled 12.5 mg metoprolol tartrate. Upon review of the medication order, MAR, and pharmacy labeling of the medication, Nurse #1 reported that Resident #28 should have been given two of the 1/2 tablets (for a total dose of 25 mg metoprolol tartrate). The nurse acknowledged she had only given Resident #28 one-half (1/2) of a 25 mg metoprolol tartrate tablet (which provided a dose of 12.5 mg metoprolol tartrate) during the medication administration pass observed. An interview was conducted with the Director of Nursing (DON) on 2/11/15 at 10:16 AM. During the interview, the DON stated that her expectation for medication administration was that nursing staff would, "follow the standards of practice." Upon further inquiry, the DON stated that the "five rights" of medication administration (referring to the right patient, the right drug, the	F 332	residentKs medications weekly x 4 and monthly x 3 for proper dosage and adequate supply.DON to monitor and report in QAA. Pharmacy consultant to conduct med passes on three nurses monthly x 3.DON to monitor and report in QAA. Completion date 3/2/15	

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F 332	Continued From page 2 right dose, the right route, and the right time), which included the right dose of the medication, needed to be checked by the Nurse prior to administering a medication. 2) Resident #28 was admitted to the facility on 10/1/14 with diagnoses including hypertension (high blood pressure) and glaucoma (a disorder that is associated with increased fluid pressure in the eye). On 2/10/15 at 4:47 PM, Nurse #1 was observed as she prepared medications for Resident #28. During the preparation of the medications, Nurse #1 reported that the resident was out of dorzolamide/timolol ophthalmic solution (a combination eye drop medication used for the treatment of glaucoma). The nurse stated that the eye drops would be delivered by the pharmacy later that evening around 9:30-10:00 PM. After administering Resident #28's oral medications to her, Nurse #1 informed the resident that she was out of her eye drops (referring to the dorzolamide/timolol ophthalmic solution). The nurse told the resident that she would come back to administer the eye drops when they were delivered by the pharmacy later that evening. A review of Resident #28's physician orders revealed there was a current order (dated 10/1/14) written for dorzolamide/timolol ophthalmic solution to be instilled as 1 drop in the left eye twice daily for a diagnosis of glaucoma. The eye drops were scheduled to be given at 9:00 AM and 5:00 PM daily. On 2/11/15, the Resident #28's February 2015 Medication Administration Record (MAR) was	F 332		

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F 332	Continued From page 3 reviewed. The MAR indicated that the 2/10/15 5:00 PM dose of dorzolamide/timolol ophthalmic solution was not administered. An interview was conducted on 2/11/2015 at 8:35 AM with Nurse #2. Nurse #2 was the first shift nurse assigned to care for Resident #28. Upon request, Nurse #2 checked the hall medication cart to see if the dorzolamide/timolol ophthalmic solution for Resident #28 had been delivered by the pharmacy the previous evening (2/10/15) as expected. After inspection of the hall medication cart, Nurse #2 reported there wasn't a bottle of dorzolamide/timolol ophthalmic solution labeled for Resident #28 stored on the medication cart. Nurse #2 then stated, "I'll have to call the pharmacy." Nurse #2 indicated that she (or a supervisor) would call the pharmacy and request that their back-up pharmacy be contacted to deliver the eye drops ordered for Resident #28. An interview was conducted on 2/11/2015 at 9:30 AM with the facility ' s Nursing Supervisor. Upon inquiry, the Nursing Supervisor reported that she would have expected Nurse #1 to notify the supervisor last evening (2/10/15) that there wasn't any dorzolamide/timolol eye drops on the medication cart for Resident #28. Alternatively, the Nursing Supervisor indicated that Nurse #1 could have called the pharmacy herself to confirm that the eye drops were being delivered on 2/10/15 and when they could be expected. Upon checking the facility's Omnicell (a medication dispensing system that securely stores prescription medications on-site at the facility), the Nursing Supervisor discovered that a bottle of dorzolamide/timolol ophthalmic solution was stocked and available from the facility's Omnicell.	F 332		

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F 332	Continued From page 4 An interview was conducted on 2/11/2015 at 10:16 AM with the facility ' s Director of Nursing (DON). During the interview, the DON indicated that her expectation would have been for Nurse #1 to obtain the dorzolamide/timolol eye drops when it was discovered that Resident #28 was out of them on 2/10/15. The DON stated that Nurse #1 should have obtained the ordered eye drops from either the Omnicell (available within the facility) or requested delivery of the eye drops from the backup pharmacy on 2/10/15.	F 332		