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 08/02/2017

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CAMDEN PLACE HEALTH AND REHAB, LLC	1 MARITHE COURT GREENSBORO, NC 27407

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F 000	INITIAL COMMENTS IDR 9/18/17 resulted in deletion of F 157	F 000	The facility was cited for the failure to accurately code the MDS assessment in the area of falls for resident #4. The facility's process requires tthat the MDS be coded accurately according to the RAI Manual. The MDS assessment for resident #4 was reviewed and a proper modification was made to sections J1700 and J 1800 of resident #4's MDS before 8/23/17. A 100% audit of section J 1700 and J1800 for all resident's most recent MDS will be completed by the facility MDS consultants and MDS nurses to ensure coding accurately reflects the resident's status before 8/30/17. For any areas of concern identified, a modification or or significant correction will be completed by the facility MDS nurse or MDS nurse consultant before 8/30/17. All disciplines responsible MDS coding will be educated regarding accurate coding of MDS assessments per the RAI manual before 8/30/17	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement.	F 278		8/30/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sue McLaughlin-Bass | TITLE: Administrator | (X6) DATE: 08/23/2017

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 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of falls for 1 of 8 sampled residents (resident #4) reviewed for MDS accuracy. Findings included: Resident #4 was admitted to the facility on 4-7-14 with diagnoses that included unspecified dementia without behaviors, vascular dementia, age related osteoporosis, personal history of traumatic brain injury. A review of the Minimum Data Set (MDS) dated 5-22-17 revealed resident #4 did not have any falls since last assessment dated 2-28-17. A review of nurse's notes dated 5-30-17 revealed resident #4 had 2 falls. One timed at 3:30pm and the other note was timed at 10:30pm. A review of the fall incident log revealed resident #4 had a fall on 6-4-17 at 7:15pm. There was no documentation of this fall found in the nurse's notes. A review of the Minimum Data Set (MDS) dated 6-20-17 revealed resident #4 required one person assist with ADL's and transfers. MDS also revealed resident had not had a fall since last assessment dated 5-22-17. Interview with MDS coordinator #3 on 8-2-17 at 8:00am stated that she was new and started in March of 2017. The MDS coordinator #3 stated that she relied on what was in the electronic medical record to base her scores. She further	F 278	Facility MDS consultant will audit 10 percent of all MDS completed weekly for accuracy in all sections for four weeks. All areas identifed to be of concern will be addressed immediately by te MDS consultant with retarining of appropriate staff making the error. MDS nurse will complete modifications or significant correction to assessments as indicated. A QI tool will be utilized QI audit tools will be submitted to the QI committee for review monthly for and revision of the plan as indicated.	

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F 278	Continued From page 2 revealed that she only looked at the incident logs and nurses notes in the electronic record when she was scoring for falls. Interview with the Director of Nursing (DON) on 8-2-17 at 7:30pm stated the MDS coordinator was responsible for updating care plans and the MDS. The DON stated the MDS coordinator received the information from attending the morning meetings, reviewing the twenty four hour report and physician orders. The DON stated that she expected the MDS coordinator to update the care plans and MDS accordingly.	F 278	The facility was cited related to the failure to implement and revise care plan realted to fall interventions for resident #4. The facility's process requires resident's at risk for falls have a interventions implemented to mitigate fall risk on admission. Facility processes also require a resident's care plan be reviewed and revised implemented post fall. Resident #3 and resdent #4's medical records were reviewed for last 90 days to identify fall history. Based on record review, interventions related to fall risk willl be implemented and resident care plan updated. Administrive staff will conduct 100% audtit of all resident medical records for the last 90 days to identify resident fall history. Resident's identified to lack appriopriate care plan interventions will have their care plan reviewed and revised as indicated. Licensed Nursing Staff will be inserviced by the staff development coordinator regarding steps to take after the a resident fall, including the implementation of immediate intervention. Adminstraive nursing staff to include MDS, ADON, SDC, and DON Will be educatued reagrding timeliness for updating resident care plan after a resident falls	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan	F 280		8/30/17

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F 280	Continued From page 3 of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 280	Adminsitrive Staff (DON, SDC, MDS) will review nursing notes five times/ week for four weeks to ensure all resident falls have been identfied and appropriate interventions added to the resident plan of care. IDT team will review resident incidents five times weekly for four weeks to enusre an approiate intervention has been implemented post fall and the resident plan of care is updated as indicated. A QI tool will be utilized. Results of QI audit tools will be submitted to the monthly quality committee for review. Quality committee will rveiw and revise plan as indicated.	

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F 280	Continued From page 4 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on chart review and staff interviews, the facility failed to review and revise the plan of care in the area of falls for 2 of 8 sampled residents (Resident # 3 and Resident # 4). Findings included: 1: Resident #3 was admitted to the facility on 9-17-15 with multiple diagnosis that include CVA, Diabetes, Hypertension and history of UTI's. The quarterly Minimum Data Set (MDS) dated 7-8-17, coded resident #3 with minimal to no cognitive deficits. The MDS did code for falls. Review of nurse's notes dated 7-6-17 stated the wheelchair rolled away from the resident when he was trying to sit down and resident fell. The comprehensive plan of care was noted not to be updated related to resident #3 fall on 7-6-17 till 7-31-17. The updated plan of care in part included; Patient not experiencing serious injury	F 280		

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F 280	Continued From page 5 from falls requiring hospitalization, Therapy as ordered, Ensure wheelchair wheels are locked and observe resident for any signs or symptoms that may cause a fall. Interview with Director of Nursing (DON) on 8-2-17 at 7:30pm stated that she expected the MDS nurse to update the plan accordingly. 2: Resident #4 was admitted to the facility on 4-7-14 with multiple diagnosis that include; Dementia, Anxiety and Anemia. The quarterly Minimum Data Set (MDS) dated 7-6-17 coded resident cognitively impaired. MDS did not reflect that the resident had any falls. MDS dated 6-20-17 also did not reflect that the resident had any falls. Chart review revealed the resident had 2 falls on 5-30-17 Review of fall log for June noted resident #4 had a fall on 6-4-17.This was not documented in the nurse's notes. The comprehensive plan of care dated 1-1-2016 was last updated in the chart and in the electronic medical record 5-30-17. There was an update following the 5-30-17 fall revealing the family was to provide the resident with appropriate footwear to include no skid souls. The fall care plan noted on 5-30-17 included; Resident will not have any falls requiring medical attention, maintain resident environment free of clutter and safety hazards, place items within reach of the resident, place call light within reach of the resident and family to provide appropriate footwear to include nonskid souls.	F 280		

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F 280	Continued From page 6 Interview with Director of Nursing (DON) on 8-2-17 at 7:30pm stated that she expected the MDS nurse to update the plan accordingly.	F 280		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and family interviews, the facility failed to assess skin breakdown on 1 of 3 residents (Resident #6). Findings included: Resident #6 was admitted to the facility on 10/27/16. Diagnoses included, in part, dementia and unstageable pressure ulcers. The Minimum Data Set quarterly assessment dated 4/20/17 revealed Resident #6 was severely cognitively impaired. Resident #6 was coded for	F 314	The facility was cited related to the failure to identify and intiatie treatment for a new skin finding for resident #6. The facility's process requires that staff observe resident for skin abmormality while proidng care and immediately report any abnormal findings to the licensed nurse for immetiate treatment intervention by the licensed nurse. New areas Identified for resident #6 was assessed by facility wound nurse and treatment initiated at the time of survey. Resident Plan of Care updated as indicated Administrive Nursing staff will complete full body skin assessments of all residents currently in house to identify any unreported skin changes. Licensed nursing stafff will intitiate treatmant for any new skin abnormality noted during skin assessments.	8/30/17

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F 314	Continued From page 7 being at risk for developing pressure ulcers as well as having an existing stage 3 pressure ulcer, pressure reducing device for chair and bed, and to treat pressure ulcers. A review of a care plan updated on 3/16/17 revealed a potential for alteration in skin integrity with an intervention to include float heals as ordered. A review of a care plan updated on 6/2/17 revealed a potential for alteration in skin integrity with interventions which included perform skin checks and provide treatment as ordered. An observation of Resident #6 on 8/1/17 at 10:05 am revealed an alert but not aware for time and place resident. The resident was lying in her bed and a wound vacuum (a mechanical device for wound treatments) was in place for a wound to her buttocks. The resident was noted to have bilateral off-loading boots to her feet which were formed and had padding on the inside. The padded area where the toes rested were noted to cover the entire foot including the toes. An observation of Resident #6 on 8/1/17 at 11:30 am revealed a family member (FM) (a previous caregiver) was sitting with the resident. The resident was in bed with the bilateral off-loading boots on her feet. An interview with the FM on 8/1/17 at 11:30 am revealed she was concerned about the skin breakdown areas located on Resident #6 ' s feet. The FM stated she felt as though the boots were causing friction and causing the skin to breakdown. The FM stated they had been there for about a week. The FM stated she had not	F 314	Nursing staff will be inservcied by the DON or SDC regarding indentification and immediate reporting of new abnormal skin conditions and immediate implemention of treatment for new skin condition identified. Licensed nurses will conduct head to toe observation of resident skin weekly for eight weeks. Licensed nurse will implement immediate interventions for abnormal skin findings and forward abnormal skin findings noted weekly observations to the quality committee for review. All abmormal skin fidnings noted on weekly assessments, will be reviewed in the monthly quality committee to identify trends related to immediate identification of new skin condition and update plan of action as indicated.	

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F 314	Continued From page 8 reported it to any staff member but figured they would have seen them by now. An observation of Resident #6 on 8/1/17 at 11:30 am revealed she was noted to have skin breakdown to the side of the right 5th toe where the toe rested against the off-loading boot. Additionally, skin breakdown was also noted on the side of the left great toe where the toe rested against the off-loading boot. Both toes were noted to be red in color with brown discoloration on the bony prominence. The wounds were not opened. A review of the physician ' s orders on 8/1/17 at 11:45 am revealed there was no orders for treatment for Resident #6 ' s feet. An observation of Resident #6 at 9:30 am on 8/2/17 revealed the resident lying in bed with bilateral off-loading boots on her feet. The skin breakdown to the side of the right 5th toe and left side of the great toe were noted to be red in color with brown discoloration noted on the boney prominence. The wounds were not opened. An observation of Resident #6 at 2:30 pm on 8/2/17 revealed the resident lying in bed with bilateral off-loading boots on her feet. The skin breakdown to the side of the right 5th toe and left side of the great toe were noted to be red in color with brown discoloration noted on the boney prominence. The wounds were not opened. An interview with NA #1 on 8/2/17 at 2:30 pm revealed she took care of Resident #6 frequently. She reported she removed the off-loading boots when she did patient care on the resident today but she did not notice the skin breakdown on her	F 314		

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F 314	Continued From page 9	F 314		

bilateral feet. NA #1 indicated if the nursing assistants noticed any new skin breakdown, rashes, redness or swelling, they were educated to report the concerns to the nurse.

An interview with the wound nurse on 8/2/17 at 2:30 pm revealed if any of the nursing staff identified concerns with a resident that needed skin care treatment they would let her know. The nurse stated she changed the wound vacuum for Resident #6 every Monday, Wednesday and Friday. The nurse stated she was not aware of any new skin issues for Resident #6 except that she had an area below the right great toe that had a scab which she started a treatment yesterday (8/1/17) afternoon. The nurse proceeded to remove the right off-loading boot and revealed the scabbed area below the right great toe. The wound nurse began to reapply the off-loading boot back on the right foot. The wound nurse did not reveal the skin breakdown to the bilateral feet. At this time, the areas of concern were pointed out to the wound nurse. The wound nurse stated this was her first time seeing the skin breakdown on the right and left toes. The wound nurse stated at this time, the skin breakdown was probably from the bilateral boots rubbing her toes and removed the boots from Resident #6.

An interview with Resident #6 ' s assigned Nurse #2 on 8/2/17 at 4:20 pm revealed she was not aware of any new skin issues on Resident #6. Nurse #2 reported she knew the resident had a wound vacuum. She reported she did a head to toe assessment on her residents each shift. Nurse #2 reported she did not see any skin breakdown on Resident #6 on 8/1/17 during the 3:00 pm - 11:00 pm shift. Nurse #2 reported she had not done her assessment on Resident #6 as

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F 314	Continued From page 10 of this time, but no one reported to her that she had any new skin breakdown. Nurse #2 stated skin assessments were also done weekly on Resident #6. An interview with the Director of Nursing (DON) on 8/2/17 at 7:00 pm revealed her expectation of the nursing staff was to assess the resident ' s skin and report any new concerns to the nurses so a treatment could be put in place.	F 314		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 323	The facility was cited related to the failure to implement and revise fall interventions for resident #4. The facility's process requires resident's at risk for falls have a interventions implemented to mitigate fall risk on admission. Facility processes also require a resident's fall interventions to be revised implemented post fall to prevent subsequent falls. Resident #4 medical record was reviewed for last 90 days to identify fall history. Based on record review, interventions related to fall risk willl be implemented before 8/30/17. Resident Plan of Care will be updated as indicated before 8/30/17	8/30/17

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F 323	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, observation and resident interview the facility failed to have interventions to prevent repeated falls for 1 of 8 (Resident #4) sampled residents. Findings included: Resident #4 was admitted to the facility on 4-7-14 with multiple diagnosis that include Dementia, Anemia and Anxiety. A review of the Quarterly Minimum Data Set (MDS) dated 7-6-17 revealed resident #4 was cognitively impaired without any falls.The MDS revealed the resident needed extensive assistance with 2+ persons in the areas of bed mobility, transfers and toileting. MDS also revealed that resident #4 was total care in bathing with one person assist. A review of the Quarterly Minimum Data Set (MDS) dated 6-20-17 showed that resident #4 was cognitively impaired without any falls. The MDS revealed resident needed extensive assistance with one person in the areas of bed mobility, transfers and toileting. The MDS also revealed resident #4 needed physical help in bathing with one person assist. A review of the Quarterly Minimum Data Set (MDS) dated 5-22-17 showed that resident #4 was cognitively impaired without any falls.The MDS revealed that resident #4 needed extensive assistance with one person in the areas of bed mobility, transfers and toileting. The MDS also revealed resident #4 was total care in bathing with one person assist.	F 323	DON or designee will conduct 100% audtit of all resident medical records for the last 90 days to identify resident fall history. Based on record review interventions will be implemented as indicated, to be completed on or before 8/30/17 Resident's plan of care will be updated by facility MDS nurse as indicated. Licensed Nursing Staff will be inserviced by staff development nurse regarding the need for immediate intervention after a resident falls and the processs for reporting falls to the IDT team for review, before8/30/17 Adminsitrive Staff (DON, SDC, MDS) will review nursing notes five time/ week for four weeks to ensure all resident falls have been properly reported to the IDT team for review. IDT team will review resident incidents five times weekly for four weeks to enusre an approiate intervention has been implemented post fall and the resident plan of care is updated as indicated. A QI tool will be utilized.	

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	345547	A. BUILDING _____ B. WING _____	C 08/02/2017

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F 323	Continued From page 12 A review of the Care Plan dated 1-1-16 with the last review on 5-30-17 revealed that resident #4 would have no falls requiring medical attention over the next 90 days, maintain the residents environment free of clutter and safety hazards, place items within reach, place call light within reach and the family was to provide appropriate footwear with nonskid souls. A review of the nurses notes dated 5-30-17 revealed that resident #4 had 2 falls on 5-30-17. The first fall occured at 3:30pm in the bathroom. The note revealed the resident was trying to transfer herself from her wheelchair to the toilet and fell.Then note also revealed the resident had on slick souled shoes at this time. The second fall occurred at 10:30pm also in the bathroom. The note revealed the resident was trying to get a shower on her own and fell. The note also revealed resident was barefoot at this time. A review of the fall investigation sheets revealed that resident #4 had a fall on 6-4-17. This fall was not documented in the nurse's notes. The fall investigation sheet showed the fall occurring at 7:15pm in the resident's room. The fall investigation sheet revealed resident #4 was trying to transfer herself into bed and fell. The fall investigation sheet also revealed this was the residents 3rd fall. A review of the chart revealed a physical therapy evaluation order on 6-5-17 which was completed on 6-9-17. An interview with nurse #6 occured on 8-1-17 at 11:35am. Nurse #6 stated that resident #4 can get up on her own but should have at least a one person assist. Nurse #6 stated resident showers	F 323	Results of QI audit tools will be submitted to the monthly quality committee for review. Quality committee will rveiw and revise plan as indicated	

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F 323	Continued From page 13 every day with assistance. Nurse #6 also stated resident had not had any falls over the last 30 days. An interview with the nursing assistant (NA #3) occured on 8-1-17 at 11:45am. NA #3 stated she checked on resident #4 every 2 hours and assisted with toileting at that time. The NA #3 stated resident was a one person assist. An interview with Resident #4 occured on 8-1-17 at 11:55am. Resident #4 was disoriented to time and date but was aware she was in a nursing home. The resident stated she liked receiving showers everyday but that she does not always get one. The resident was unable to answer regarding transferring on her own but did state she has a "button" in her room she pushed for help. An interview with nurse #7 occured on 8-1-17 at 4:15pm. Nurse #7 revealed she was the nurse working on 5-30-17 when resident #4 had fallen. Nurse #7 stated she remembered the resident complained of left shoulder pain. The nurse also stated the resident had chronic left shoulder pain due to arthritis. Nurse #7 described the resident as "still being very independent". The nurse stated she increased the amount of supervision for resident #4 by increasing the frequency of checks during her shift (3-11pm). Nurse #7 stated this intervention did not become part of the residents Care Plan. The urse stated she implemented this intervention on her own for her shift. An interview with The Director of Nursing (DON) occured on 8-2-17 at 10:20am. The DON revealed staff have a falls meeting every morning	F 323		

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F 323	Continued From page 14 that is attended by the DON, the Assistant DON, Therapy, the Supervisors and the MDS coordinator. The DON revealed staff discussed interventions if falls have occurred. She stated if the interventions changed from the care plan, that this was verbally communicated to staff. The DON also revealed if a resident was having multiple falls, staff would transfer the resident to a common area, change the residents room closer to the nursing station or ask family to provide a sitter. An interview with resident #4 occured on 8-2-17 at 10:50am. The resident was in her room still in her night gown. The resident stated she was waiting on staff to come give her a shower and help her get dressed. The resident stated she had asked nurse #6 to help her but the resident could not remember how long ago. An interview with a nursing assistant (NA #4) occured on 8-2-17 at 11:00am. The NA stated resident #4 was a 2 person assist. The NA revealed she received a report every morning before shift and the form told her about each resident and their care. NA #4 stated that resident #4 was listed as a 2 person assist. An interview with the Physical Therapy (PT) supervisor occured on 8-2-17 at 1:10pm. The PT supervisor revealed family did not want resident #4 to have therapy at first but that staff had a meeting with the family and the family agreed to strengthening exercises. The PT supervisor stated she believed the resident would be a transfer with one assist. She also stated that resident #4's therapy ended the end of June. An interview with the Director of Nursing (DON)	F 323		

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F 323	Continued From page 15 occured on 8-2-17 at 7:30pm. The DON stated her expectation to prevent falls was for her staff to "do the best they can" to prevent further falls.	F 323		