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 12/11/2019

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

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E 000	Initial Comments An unannounced recertification survey was conducted 12/1/19 through 12/11/19. The facility was found in compliance with CFR 483.73 Emergency Preparedness. Event ID - 59GR11.	E 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, medical doctor, family and staff interviews the facility failed to protect 1 of 3 residents (Resident #11) from two injuries of unknown origin. The first injury resulted in a laceration to the right side of her head, an abrasion to her right check and bruises to her right shoulder and right knee. The second injury resulted in a laceration to the top left side of her head that required transfer to the emergency room (ER) and 4 staples to the head laceration. Findings included:	F 600	F600 Free from Abuse and Neglect The facility conducted two thorough injury of unknown origin investigations for Resident # 11. Both investigations were found to be unsubstantiated for abuse. On both incidents, Resident # 11 was assessed, and care provided, for the first incident resident was assessed by the NP, orders were obtained for bandages to the forehead, other areas identified were to	1/9/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/09/2020

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F 600	Continued From page 1 1a. Resident #11 was admitted to the facility on 3/22/2016 with diagnoses that included Alzheimer's disease with late onset, abnormal posture, contractures of both hands, restless leg syndrome and cognitive communication deficit. A review of the resident's physician order revealed the resident was not on anticoagulant medication (a medicine that increase the risk of bruising). Review of an Annual Minimum Data Set (MDS) dated 4/22/2019 revealed Resident #11 was rarely understood. Resident #11 needed extensive assistance of one person with bed mobility, eating, and personal hygiene. Resident #11 was totally dependent on one person's assistance for dressing, toileting and bathing. Resident #11 was always incontinent of bowel and bladder and no behavioral symptoms were identified on this MDS. Resident #11's care plan dated 4/23/2019 identified a problem with activities of daily living. Interventions included to provide assistance with activities of daily living, mobility and transfers as needed, to be careful not to overwhelm the resident and provide privacy and converse with the resident while giving care. During an interview with a family member (FM) for Resident #11 on 12/1/19 at 2pm, she revealed the resident had been in the facility since 2016. The FM indicated several months ago the resident received several injuries of unknown origin that she could not inflict herself. The FM revealed the resident had some bruises on her body and a laceration on her forehead. She added the injury on her forehead required	F 600	be monitored for any further bruising. An x-ray was ordered to r/o fracture—this was negative, for the second incident resident was checked by the RN supervisor and an order was obtained from on-call MD to send resident to the ED, at the ED a CT scan was completed which was negative and 4 staples were placed to the laceration. With both incidents, the resident was immediately protected. No staff or other residents were identified as having the potential to have caused the incident. The resident is able to move about the bed as witnessed by multiple staff members, and members of the management team. The resident does require mechanical lift for transfers and is unable to perform ADL's so she is dependent on staff to meet her basic needs but does have the ability as stated about to move herself in the bed. Resident does have a diagnosis and history of seizures. It is believed that Resident #111 had a seizure on these two events which resulted in both injuries. However, the root cause as to what happened in both events can not be determined fully, because there are no witnesses to either event, but the facility feels resident could have had a seizure. A 100% audit was conducted at the time of each allegation/event by facility administration/DON/Administrator to include an interview of each alert and orientated resident and skin checks and observation were done on dependent residents, with no additional allegations noted. The 1st 100% audit was completed	

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treatment at the ER and staples to close the incision. The FM had concerns about how these injuries happened as the resident was not able to move and was nonverbal.

Review of a nursing "resident progress note", written by Nurse #7, dated 6/6/2019 at 11:12pm revealed a Nursing Assistant (NA) #20 called (Nurse #7) to Resident #11's room because she had an area on the right side of her face. This writer noted the resident had a small red open area to the right temple and a red area to her right upper cheek with a small indentation in center. The NA stated she did not notice it earlier when she fed the resident supper. NA #20 stated the resident was positioned on her back and the resident was currently lying on her left side. The resident's legs and arms were contracted. Nurse #7 documented in the progress note that Med Aide (MA) #21 noted, when she went in at 6:50pm to give Resident #11 her medications, her right hand was balled up beside the area and the hand was pressed against her face. Fingernails were at normal length but difficult to cut due to contracture on the hand. The nurse supervisor was called to assess the resident. The family was contacted and made aware. The nurse supervisor assessed the resident and the Director of Nursing (DON) was made aware and will continue to monitor the resident.

The summary of investigation for injury of unknown origin for Resident #11 dated 6/13/2019 read "Resident was assessed by the treatment nurse and RN supervisor when they were made aware of the injury. The DON assessed the resident upon report of incident. Family and Nurse Practitioner were notified immediately. The NA that took care of the resident and the MA that

on 6/13/2019 when alert and oriented residents for interviewed for abuse and neglect. Skin checks were completed on 6/17/2019 on all dependent residents. The 2nd 100% audit for all alert and oriented residents was completed on 10/4/2019 and skin checks on all dependent residents was completed on 10/4/2019.

The Staff Development Coordinator will educate all staff on signs and symptoms of abuse and neglect, and reporting incidents/accidents of abuse. This will be completed on 1/9/2020.

All clinical staff will be educated on lift training/transfer techniques and signs and symptoms of caregiver burnout. This will be completed on 1/9/2020. Abuse training is done on orientation, annually and after any occurrence of alleged abuse. Lift training is done during orientation with return demonstration, and annually. Caregiver burnout and stress management will now be incorporated into orientation and annually beginning with the 1st orientation in February 2020.

Nursing Staff will do weekly skin checks to identify any signs of abuse. Any adverse findings will be reporting immediately to the Director of Nursing (DON) for further investigation. As per MD order, skin checks are to be completed weekly on-going. Facility will be compliant 1/6/2019 and ongoing for weekly skin checks.

The SW/designee will conduct interviews

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F 600	Continued From page 3 provided medication during the evening shift when the injury occurred were both questioned and statements were included. The LPN care coordinator, who first found the injury also was questioned and the statement was included. The NA that cared for the resident when the injury was found denied anything happened while she cared for the resident, but the injury occurred while she was on duty and providing care to the resident. The aide was suspended and then terminated on 6/11/2019. Family was informed of the outcome of the investigation." During an interview with Nurse #7 on 12/3/19 at 10am, she revealed she was the nurse on duty on 6/6/2019. She indicated she was called to the room by NA #20 who was assigned to Resident #11 that evening. Nurse #7 revealed she walked in the room and saw that Resident #11 had bruises and laceration on her right side. Nurse #7 stated that NA #20 "raised her hands in the air and stated, 'I did not touch her' in a defensive tone". Nurse #7 revealed the resident was observed to have had a small red open area to the right temple. Right below the upper cheek was a red area with small indentation in the center. Nurse #7 also stated the resident had a bruise on her shoulder, hip and knee. Nurse #7 indicated she asked NA #20 if the resident had fallen and the NA stated no. Nurse #7 revealed this resident was not able to inflict on herself the injuries observed. She added she had been working with the resident for several years and the resident was not able to make her needs known to staff. Nurse #7 revealed Resident #11's hands were contracted and would not have been able to do injury to herself. Nurse #7 indicated she believed NA #20 caused Resident #11 to fall off the bed, put her back in bed and then called the nurse to the room. Nurse #7 indicated she	F 600	of alert and oriented resident for any allegations of abuse weekly x 4 weeks and then monthly. The nursing staff will do weekly skin checks on alert and oriented residents and dependent residents weekly per MD order. Any adverse findings will be reported immediately to the Director of Nursing for further investigation. Social Worker/designee will conduct interviews with alert and oriented residents for abuse and discuss with family/caregiver of non-alert and confused residents on admission, quarterly and at discharge meetings. Social Worker/designee will conduct 5 random interviews for abuse weekly x 4 weekly, then monthly- ongoing. Social Workers will begin interviews on alert and oriented residents 1/6/2020. All findings will be brought to QAPI monthly by facility Social Workers/designee ongoing. If any issues are identified, they will be addressed at this time.	

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called the director of nursing (DON) and Administrator with this information. She added due to this incident NA #20 was terminated because of this injury.
NA #20 and MA #21 were called several times during this investigation and did not return the calls.
An interview with NA #12 on 12/3/19 at 11am revealed she had only worked with Resident #11 a few times and to her knowledge this resident would not be able to inflict any of the injuries to herself.
Review of a note from medical doctor (MD) dated 6/11/2019 at 11:24pm indicated the resident was seen on 6/11/19. On evaluation, the resident did not exhibit any sign or symptoms of pain. An abrasion was noted to the right side of her forehead and below her lower right eyelid. Unable to obtain any history from the resident due to her non-verbal status and Alzheimer Dementia.
During an interview with the DON on 12/4/19 at 1pm she revealed during this investigation she was able to get statements from staff and all alert residents were interviewed. She stated no issues with abuse or mistreatment by staff were identified. The DON revealed the facility followed the state guidelines for reporting and investigation of injuries of unknown origin. DON indicated that she felt that NA #20 may have caused Resident #11 to fall off the bed and then placed her back in the bed and then called Nurse #7. However, the DON asked NA #20 the question and NA #20 denied it. DON also revealed that NA #20 was termination because she was the one that provided care for Resident #11 on 6/6/2019.
1.b Review of a quarterly Minimum Data Set (MDS) dated 9/15/2019 revealed Resident #11 had moderately impaired cognition, required one-person assistance with bed mobility,

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transfers and locomotion, and required extensive one-person assistance with dressing, toileting and personal hygiene. Resident #11 was incontinent of bowel and bladder and no behavioral symptoms were identified on this MDS.
A Review of Resident #11's nursing "resident progress note", written by Nurse #7 and dated 9/28/19, indicated "NA #11 came and informed this writer he noted the resident had some blood on her pillow. I noted the resident had some blood on her hair on top left side. I removed pony tail holder from her hair to further assess area. Noted that resident had a small gash to top left side of head. Called supervisor in to assess area. Supervisor assessed and called the on-call clinician for orders. New order received to send to ER for evaluation. Family called and made aware. Supervisor also called family and told them that 911 was called and resident was going to hospital. Resident left at 6:35pm."

Review of the hospital record dated 9/29/2019 for Resident #11 revealed she was transferred from nursing facility for evaluation of a head laceration. The resident was found at approximately 6:15 pm this evening with blood on her pillow and staff noticed a laceration to the left side of her head. The staff were unsure how the laceration occurred. The ER physician spoke with the facility nurse supervisor who stated the resident was not mobile and required assistance from staff to be transferred and there were no reported falls. The nurse supervisor stated the resident was last seen at about 4:30 or 5:00 pm when she was transferred from a chair into the bed. At that time, she had no evidence of laceration. The resident's family was at bedside, denied any blood thinner use and reported the resident was at her mental

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baseline. Physical exam revealed a 3-centimeter (cm) laceration to her head and received 4 staples to the head laceration. The resident tolerated the procedure well and no other obvious injuries were noted on physical exam. A cat scan (CT) of the head was ordered and did not reveal any evidence of brain bleed. The resident was stable for discharge.

A review of nursing resident progress note dated 9/29/19 at 1:03am stated the resident arrived back to the facility with a diagnosis of laceration of the scalp. Resident was noted with staples to the left side of her head with instructions to apply Neosporin and bacitracin twice daily to area and staples to be removed in 5 to 7 days. Resident was provided care and placed comfortably in bed.

Review of a physician progress note for Resident #11 dated 10/2/2019 stated the resident was seen for follow-up to a laceration that required an ER visit. The resident was sent to the ER for a scalp laceration; it was unclear how this happened. The resident's family expressed a concern that the resident may be in pain. The resident was seen yesterday by a team member who treated the resident with Tramadol 25 mg twice daily. She did receive Tramadol this morning, but she is non-verbal and difficult to evaluate. The staff reported no changes in the resident's baseline. The Hospice nurse had noticed a vague change yesterday that could have been pain. Resident appears to be tolerating the low dose of Tramadol.

A review of the Report of Investigation of Resident #11 dated 10/4/2019 stated Resident #11 was admitted to facility on 3/22/2016 with admitting diagnoses of Alzheimer's Disease with

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late onset, abnormal posture, contractures and anxiety disorder. On 9/28/2019 Resident #11 was identified for an injury of unknown origin. Small traces of blood were noted on the resident's pillow while the NA was feeding her. Nursing supervisor assessed and found the resident lying in bed with small amount of blood in her hair. A small laceration was found on the top left side of the resident's head. Nursing supervisor cleaned the area with gauze and applied pressure. The nursing supervisor then notified the DON who instructed staff to transfer the resident to the ER for further evaluation. Prior to the resident being transferred to the ER, the DON and RN discussed the incident to identify what could have caused this injury of unknown source. The resident was unable to communicate and therefore was unable to indicate how this injury occurred. The DON walked through a comprehensive timeline of events and was unable to conclude at that time what could have caused this injury. The nursing supervisor contacted the family and the Administrator and 24 hour "reportable" was faxed. The facility began an immediate investigation. The NA that was responsible for taking care of the resident was removed from her assignment immediately. Resident #11 returned to the facility at 1:03 am. The resident returned with four staples in her head and new order to apply Neosporin and Bacitracin twice a day and removal of staples in 5 to 7 days. The resident was placed comfortably in bed and vital signs were obtained.

A Review of a form called, Summary of notification on Resident #11 injury of unknown origin, completed by the DON revealed, on 9/28/19 the RN supervisor called the DON to make her aware of a laceration on the top left

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side of Resident #11's head. The nurse reported that NA and Med Aide noticed a scant of blood on the resident's pillow. They notified the charge nurse to check the resident and when she did, she called the RN supervisor to see the resident immediately. After the RN supervisor checked the resident, she called the DON to notify her of the injury. The DON instructed the RN to notify the MD on call and call the responsible party (RP). Then the DON went through the resident's day to identify anything that may have caused the injury. The DON asked the RN multiple questions about the resident's activities throughout the day to see if something may have occurred. The DON also asked the RN to interview all the NAs that cared for the resident throughout the day. The DON instructed the RN to examine the bed, around the room, the Geri-chair, and the resident's fingernails to see if there was any additional blood on these items. RN also informed the DON the resident was out of bed in a geri-chair most of the day, and the shift NA reported combing the resident' hair and putting it in a bun on top of her head and there was no injury on her head at that time. The evening NA reported he was feeding the resident when the med aide MA#10 came in and saw the blood on the pillow but did not see any injuries. RN was then instructed to send the resident to the ER for care and treatment of the laceration per MD order. The DON also instructed the RN to begin the 24-hour abuse investigation and fax to the registry as soon as possible to comply with the 2-hour requirement. The DON then notified the administrator of the reportable injury and instructed him of what was done. It was also noted that Resident #11's roommate was unable to communicate event in question due to her dementia and cognitive status. The facility did move the roommate of Resident #11 to another

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room while the investigation was on-going. It was stated based upon resident and staff interviews as well as there were no staff members identified or accused, the facility was unable to substantiate that abuse to Resident #11 occurred. The facility did recognize that an injury did occur but was unable to ascertain how Resident #11 received it. Due to Resident #11's dementia and Alzheimer's, she was unable to communicate how she sustained the laceration. Upon review of facility fall logs Resident #11 did not have any reported falls that could have caused this injury.

A review of form called "Report of Investigation" dated 10/4/2019 revealed on 9/30/19 the facility began to interview alert and oriented residents to identify if they saw any abuse or mistreatment of Resident #11, themselves or any other residents. There were no negative responses to indicate that they were abused, saw any abuse or knew of any abuse. The Facility Social Workers and other personnel were responsible for completing this task. The Administrator and Nurse Consultant began to interview staff. Floor staff, Dietary staff, Housekeeping and Therapy Staff were all interviewed and questioned to identify if they had any knowledge of how Resident #11 received this injury of unknown source, if they knew how could it have happened and if they knew how to report abuse and injury of unknown origin. There were no negative results or conclusive comments that indicated anyone had any knowledge of the event in question. No staff members interviewed knew anything about the injury or saw anyone abuse Resident #11. The Staff Development Coordinator initiated abuse education and reporting standards to also include injury of unknown origin on 9/30/19 and was completed on 10/3/19. All staff members were given this

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education.

During an interview with Nurse #7 on 12/3/19 at 9:45 am she revealed she was also working the evening of 9/28/19. Nurse #7 revealed she called Nurse #8 to come and assess the resident. Nurse #7 indicated that she and other staff member looked in Resident #11's room for any items that would have caused this injury to her head. Nurse #7 did recall the resident's roommate was not in the room during the time the NA was feeding this resident. Then the med aide came in to give Resident #11 her medication and that was when they saw the blood on her pillow. Nurse #7 indicated she pulled the resident's hair back and noted a small gash/laceration with bright red blood around the area. She stated she called Nurse #8 who spoke with both NA #11 and MA #10 and then called the DON and Administrator. Nurse #7 stated EMS was called, and the resident went to the ER. Nurse #7 revealed that Resident #11 and her roommate had been together for close to two years. Nurse #7 also revealed this was the second injury of unknown origin and Resident #11 did not have the ability to inflict the injuries to herself. She added the resident could not reach out to her head, face or any part of her body.

An observation of Resident #11 on 12/3/19 at 10:30 am revealed the resident was in bed facing the window in her room. Resident #11 was not able to answer any questions.

Resident #11 was observed being transferred from the bed to a chair on 12/3/19 at 10:45am. The resident was transferred using a mechanical lift and no sharp objects were observed on or around the lift.

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During an interview with NA #10 on 12/4/19 at 11am, she revealed she did not recall having Resident #11 on 9/28/19 but she observed her during the day and the resident was up in her Geri-chair and no concerns were observed. NA #10 stated she had Resident #11 the day before that incident and provided care as normal. NA #10 indicated she would give Resident #11 a bath and get her up in her Geri-chair with a lift and a second staff person and assist the resident with eating. NA #10 revealed that Resident #11 required total care and she could not do anything for herself. NA #10 also indicated that hospice was present some days to help her with Resident #11. NA #10 stated she would position the resident with pillows in her chair and bed to help her be safe during the day.

The NA who was assigned to Resident #11 during the morning shift on 9/28/2019 was called, but he never returned the calls. The Administrator was requested during the survey to contact him as well and no returned calls were received.

During an interview with NA #11 on 12/4/19 at 11:45am, he revealed he was assigned to Resident #11 on 9/28/2019 during the 3pm to 11pm shift. NA #11 stated he believed he was late that day and when he got to work Resident #11 was already in bed. NA #11 remembered going to Resident #11's room to assist her with eating. NA #11 also stated that Resident #11's hands were contracted, and she would not be able to scratch or put an incision on her head. NA #11 revealed that other staff reported the resident had fallen off the bed, but when you positioned her right she would stay in place. NA #11 indicated he did not know how the incident happened to the resident.

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NA #11 added the MA was the one who identified that there was blood on the pillow and in her scalp and they reported this information to the Nurse.

During an interview with MA #10 on 12/4/19 at 1pm, she revealed she was working with Resident #11. MA #10 stated she arrived in Resident #11's room and NA #11 was assisting the resident with her dinner. MA #10 explained she noticed a substance on the pillow that appeared to be dried blood. She added a substance in Resident #11's hair appeared to be blood and was dry and some was fresh. MA #10 indicated she called the charge nurse who came in the room and observed the blood and she requested the nurse supervisor to come and assess the resident.

An interview with the Medical Doctor (MD) on 12/5/19 at 11am revealed she had examined Resident #11 after both injuries of unknown origin. The MD stated due to the resident's health condition she was not able to tell the staff what happened. The MD indicated she believed the facility investigated the incident but had not been able to determine what caused the laceration to her head. The MD explained that due to her history and diagnoses, the resident would not be able to inflict the injuries to herself because of contracture to both hands. The injuries would be very difficult to self-inflict. The MD added the resident's family and hospice had concerns the resident was in pain after this last incident and Tramadol 25 mg BID was now given for pain.

During an interview with Nurse #8 via phone on 12/11/19 at 10:46am, Nurse #8 revealed she only worked at the facility on the weekend and she

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F 600	Continued From page 13 was the Nurse that assessed the resident before she was sent to the ER. Nurse #8 explained she was called to the room by the charge nurse on that side of the facility to assess a resident who had a head injury. Nurse #8 stated she arrived at Resident #11's room and observed blood on the pillow and some blood coming from the left top side of her scalp. She added the resident's hair was matted to her scalp with a substance that appeared to be dry blood. Nurse #8 stated she applied pressure to the site and then called the DON, MD on call and the residents' family. During an interview with DON, Administrator and Corporate Nurse on 12/4/19 at 1:30pm, the Administrator indicated the facility followed the regulation for abuse with reporting and investigation of any allegation, injury of unknown origin for Resident #11. He added "we educated all staff, interviewed all alert residents and corporate staff assisted with the investigation." The DON stated the staff who had the resident during the incident of 6/6/19 were terminated. During the investigation of the 9/28/19 incident, no staff indicated harm to Resident #11. The Administrator stated that the facility following the regulation and through investigation of the incidents. He added based on resident and staff interviews as well as no staff member was identified or accused, the facility was unable to substantiate that abuse had occurred to Resident #11. He stated the facility did recognize that two injuries did occur, but they were unable to ascertain how Resident #11 received them and because of her dementia she was unable to communicate how these injuries occurred.	F 600		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		1/9/20

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F 641	Continued From page 14 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to accurately code the oral/dental status section on the Minimum Data Set (MDS) assessment for 1 of 1 resident (Resident #367) reviewed for dental services. Findings included: Resident #367 was admitted to the facility on 8/9/18 with diagnoses that included, in part, respiratory failure and atrial fibrillation. The annual Minimum Data Set (MDS) assessment dated 7/6/19 indicated Resident #367 had moderately impaired cognition. The oral/dental status of the MDS was coded as "none of the above." The MDS did not note the resident had missing teeth. An observation and interview with Resident #367 was completed on 12/5/19 at 11:55 AM. There were no teeth observed on the lower jaw except for a fragment of one tooth. Resident #367 recalled that she saw a dentist in 2018 at the facility and was told by the dentist she needed to be seen by an oral surgeon. On 12/5/19 at 12:03 PM an interview was completed with MDS Nurse #2. She said before she completed the coding of the dental status on the MDS assessment she looked in a resident's mouth and determined their oral/dental status. She reported if she observed no natural teeth or	F 641	F641 Accuracy of Assessments Facility failed to accurately code Section L of the oral/dental status section of the MDS of one of one patient's being reviewed for dental status. All patients being reviewed for the comprehensive assessments by MDS have the potential to be affected by this deficient practice and coding error. The MDS Nurse failed to check the correct box in Section L of the MDS indicating that the patient had natural teeth or tooth fragments. The MDS Nurse modified the assessment on 1/6/2020 to reflect patient # 367 had natural teeth or tooth fragments. The Administrator educated the MDS Nurses on coding accuracy on 12/5/2020. The Administrator/designee will complete 100% audit of the last 30 days of comprehensive assessments to ensure Dental Status is coded correct. The Regional Reimbursement Manager/Designee will review 5 MDS assessments and correlating	

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F 641	Continued From page 15 tooth fragments she coded the dental status as "no natural teeth or tooth fragments." She confirmed she completed the annual MDS assessment for Resident #367 and coded the oral/dental status as "none of the above." An observation of Resident #367's mouth was completed with MDS Nurse #2 on 12/5/19 at 12:09 PM, during which she assessed resident's dental status as "no teeth or edentulous." MDS Nurse #2 said she miscoded the dental section of the assessment and thought the inaccurate coding was an oversight. During an interview with the Administrator, Director of Nursing (DON) and Corporate Nurse on 12/5/19 at 2:44 PM, the Administrator indicated the facility needed consistency in the MDS office and had recruited a full time, permanent MDS Coordinator in April of 2019. The facility had also utilized part time staff in the MDS role. The DON added there was a corporate nurse consultant who audited MDS assessments for accuracy on a monthly basis.	F 641	documentation charts weekly x 4 weeks, then 2 charts weekly x 4 weeks, then 5 charts monthly x 1 month. The DON, Administrator or the MDS Coordinator will bring the findings of the audits to the Quality Assurance Meeting monthly x 3 months. If any issues are identified, they will be addressed at this time.	
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and resident representative interviews the facility failed to prevent a significant medication error for 1 of 1 sampled residents reviewed for visual deficit, when a resident (Resident #111) was not administered glaucoma eye drops from the end of	F 760	F760 Residents are Free of Significant Med Errors Facility failed to prevent a significant medication error for Resident #111 by not	1/9/20

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F 760	Continued From page 16 December 2018 to August 21, 2019 as ordered by the physician. The findings included: Resident #111 was admitted to the facility on 9-9-16 with multiple diagnoses that included glaucoma and dementia. The physician's orders were reviewed and revealed an order to administer one drop in both eyes at bedtime for Lumigan drops 0.01% for glaucoma that was placed on 10/1/18 and renewed through 6/11/2020. Review of the pharmacy medication records from November 2018 revealed that the resident's Lumigan drops were delivered to the facility on 11/13/18 and the ordered supply would last approximately 25 days. Resident #111's Lumigan drops were not delivered from the pharmacy to the facility again until 8/21/19. The Medication Administration Record (MAR) was reviewed for December 2018 through August 21, 2019 and revealed documentation that the nursing staff were signing Resident #111 was receiving her Lumigan eye drops as ordered almost daily. Review of Resident #111's eye evaluations from 2/28/19 and 6/11/19 revealed that she had severe stage open-angle glaucoma in both eyes. No significant changes were documented in the resident's eye sight from the 2/18/19 eye evaluation to the 6/11/19 evaluation. The quarterly Minimum Data Set (MDS) dated	F 760	administering medicated prescription eye drops as ordered. Lumigan Eye drops were ordered for Resident #111 on 8/21/19 and administered as ordered. Resident #111 was seen by the MD to ensure no harm had occurred due to the missed eye drops. The administering Nurse and subsequent nurses failed to re-order the eye drops for Resident #111, therefore, Resident #111 did not receive the medicated eye drops as ordered by the physician. All patients receiving prescription medicated eye drops have the potential to be affected by this deficient practice. A 100% audit of all residents receiving medicated eye drops were checked by the Nursing Administration. This audit was completed on 1/9/2020.The audit for eye drops was to ensure all residents are receiving them as ordered, they have the correct bottle of drops, they are being given as ordered and re-ordered if needed. The DON/designee will compare the resident roster for residents receiving eye drops against the monthly pharmacy billing statement to ensure eye drops are being refilled monthly as ordered. Monthly audits of the pharmacy manifest and the med carts will be conducted by the DON/designee to ensure medicated eye drops are being delivered by the pharmacy. The Staff Development Coordinator educated all Nurses and Med Aides and	

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F 760	Continued From page 17 7-28-19 revealed Resident #111 was severely cognitively impaired and required one-to-two person extensive to total assistance for her activities of daily living. Her vision was documented to be highly impaired for both the 7/28/19 MDS, as well as the most recent quarterly MDS dated 11/15/19. Resident #111's care plan initially stated on 7-31-19 revealed that she had vision deficit related to her diagnosis of glaucoma with an intervention in place to administer medications as ordered. During an interview with Resident #111's representative on 12/4/19 at 1:02 PM she stated that she had noticed that the resident's pharmacy bills had not charged for the Lumigan drops for a long time so she had notified the Director of Nursing (DON) in August 2019. During an interview with the DON on 12/4/19 at 2:01 PM she stated that Resident #111's representative had informed her of the resident's eye drops not being on her pharmacy bill August 2019. She had started an investigation at that time and found that the eye drops had not been delivered from the pharmacy from November 2018 until August 2019. She had scheduled a care plan meeting with Resident #111's family and informed them of the incident with the reorder of the eye drops. The DON stated that due to the error made, she had offered for the resident to go to the eye doctor, but the family had refused. The facility's medical director was informed of the error and had examined the resident. The DON stated that during assessments of Resident #111, there was	F 760	completed on 1/9/2020 to include prescription medicated eye drop administration and process for reordering medications. The education will be conducted on orientation and annually thereafter. Each nurse and med aide found to have the deficient practice has attended mandatory education, taken and passed a test with at least a 95% score. If further violation is found the disciplinary action policy will begin. The Director of Nursing (DON)/Designee will complete a 100% audit on all patients with orders for prescription medicated eye drops are administered as ordered. The audit will be completed by 1/8/2020. An audit tool will be used by DON/Designee to ensure prescription medicated eye drops are administered as ordered. This audit began on 1/6/2020. DON/Designee will audit daily x 1 week, 2 x week x 3 weeks; weekly x 4 weeks and monthly ongoing. All findings will be reported to QAPI monthly on-going by the Director of Nursing. If any issues are identified, they will be addressed at this time.	

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F 760	Continued From page 18	F 760		

no indication she was in pain, and that due to her cognitive impairment it was impossible to ask her questions about vision changes. She stated that a plan of correction was put into place and she was monitoring the resident's MAR and delivery dates of her eye drops to ensure she was getting them as ordered.

During an interview with Medication Aid #5 on 12/05/19 at 1:50 PM she stated that she may have documented the Lumigan eye drops as given, couldn't find the drops, and forgot to change it. She stated she had documented a few times that the medication wasn't available. When asked how to re-order the medication she said that there was a button to click on the computer that would send a message to the pharmacy to refill it and she would also notify the nurse. She stated that she had notified Nurse #7 that the medication was not available because the nurses were responsible for making sure medications were re-ordered from the pharmacy. She stated that if the medication was not available to be given, her documenting it was given was an error. She stated that the resident was unable to voice concerns about her vision, but that she had not seen any signs or symptoms to indicate she was in pain or having vision changes. When asked if she had been informed or educated about her documentation errors by the DON or administrative staff, she stated that she had not.

During an interview with Nurse #7 on 12/05/19 at 2:01 PM she stated that if there was documentation that the Lumigan drops were given when it was not available to be given, it was an oversight and an error. She said that it was possible that staff had accidently indicated the

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medication was given if they had checked the "prepare all" button on the medication administration screen, which checks all ordered medications to given, and they had not unchecked the drops when it was not available. She stated that she was not aware if the medication not being available for that extended period of time and that she educated med aides to click the re-order button if a resident was out of a medication. She stated that the resident was nonverbal, and she had not seen any signs or symptoms to indicate she was in pain or having vision changes. When asked if she had been informed or educated about her documentation errors for this particular situation for Resident #111 by the DON or administrative staff, she stated that she had not been informed of the errors she had made regarding the documentation of administration of eye drops that were not available to be given.

During an interview with Resident #111's eye doctor on 12/5/19 at 12:15 PM, he stated that was not aware of the incident regarding Resident #111 missing her prescribed glaucoma drops for an extended amount of time. He stated that the potential outcome for the resident not receiving the ordered eye drops, would be increased pressure in her eyes, pain, and vision changes. He stated that he followed national protocols for prescribing the highest dose for severe cases of glaucoma this resident had. When asked if the resident's glaucoma could have worsened due to missing months of her prescribed drops, he stated that due to her glaucoma being at the most severe stage already, that the missed drops would not have made it worse. When asked if Resident #111 would have been in pain, he

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F 760	Continued From page 20 explained that with her stage of glaucoma it was his goal to keep the pressures in her eyes below 30, and during his examination on 6/11/19 her eye pressures were well below that level and she should not have had pain with those levels. During an interview with the pharmacist on 12/05/19 at 12:38 PM he stated that the eye drops prescribed to Resident #111 were used to decrease fluid in the eyes and to increase the rate of draining fluid out of the eye. He stated that he was not aware of incident and when reviewing resident medication documentation, he must rely on the nursing staff to correctly document if the medication was administered or not.	F 760		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and	F 791		1/9/20

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F 791	Continued From page 21 (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review, the facility failed to follow up on dental recommendations for 1 of 1 resident (Resident #367) reviewed for dental services. Findings included: Resident #367 was admitted to the facility on 8/9/18 with diagnoses that included, in part, respiratory failure and atrial fibrillation. The quarterly Minimum Data Set (MDS) assessment dated 10/17/19 indicated Resident	F 791	F791 Routine/Emergency Dental Services in NF's Facility failed to ensure Resident #367 was sent to a follow-up dental appointment within a timely manner. All patients that need an outside dental consult have the potential to be affected by this deficient practice. The Transportation Director did not receive a dental consult for patient #367	

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F 791	Continued From page 22 #367 had moderately impaired cognition. The MDS coding revealed the resident had no dental issues. The care plan, updated 11/22/19, had a stated problem of "requires assist with activities of daily living" and an approach included, "Assist with dental/oral care as needed." Resident #367 was seen by the facility dental provider on 12/17/18. A comprehensive oral evaluation was completed and the dentist identified "missing teeth upper and lower and root tips present." The consult report further indicated, "Patient would like root tips extracted. Oral surgeon referral was left at the facility." The medical record revealed no further dental follow up or oral surgeon referral was scheduled or completed after 12/17/18. An observation and interview with Resident #367 was completed on 12/5/19 at 11:55 AM. There were no teeth observed on the lower jaw except for a fragment of one tooth. Resident #367 recalled that she saw a dentist in 2018 at the facility and was told by the dentist she needed to be seen by an oral surgeon. The resident added she had not heard anything from the facility about a scheduled appointment with an oral surgeon and hadn't seen the facility dentist since December 2018. Resident #367 said she had not experienced any mouth pain and wanted to get partials or dentures. On 12/5/19 at 11:26 AM an interview was completed with the Supply Coordinator. She said she scheduled resident appointments and coordinated dental services in the facility. She	F 791	from the contracted dental provider because it was misplaced. In turn, an appointment was not made and consult carried out. Dentist evaluated Resident # 367 on 12/9/2019. Dentist relayed to facility staff that Resident # 367 was not a good candidate for dentures and should only be referred to outside surgeon if problems arose. The Transportation Director will audit the last quarter of in-house dental referrals to ensure follow-up completed and appointment scheduled. The Administrator will check daily during morning meeting if referrals have been scheduled and transportation arranged. Transportation Director will bring transport/appointment log to morning meeting daily. The Transportation Director will scan and email all dental referrals and notes once received from contracted dental provider to The Director of Nursing, MDS Coordinator and Medical Records Director on an on-going basis. The Director of Nursing/Designee will sign off on all dental referrals to ensure orders have been written. A copy of the referral will be uploaded to the patient medical record by the Medical Records Director once received from the Transportation Director.	

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CAMDEN HEALTH AND REHABILITATION	1 MARITHE COURT GREENSBORO, NC 27407

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F 791	Continued From page 23 explained that when the dentist came to the facility, hand written notes were left with her when the dentist left. The Supply Coordinator then gave the handwritten notes to Medical Records. Within 24-48 hours the facility received the typed dental note which was filed in the resident's chart. She stated if the dentist made a referral for oral surgery the dentist wrote it on a referral form. The Supply Coordinator reported she was unsure if anyone read the dental consult note with the oral surgery recommendations from December 2018 and said, "At that time we were transitioning to electronic filing." An interview with the Medical Records Clerk on 12/5/19 at 11:45 AM revealed she was unsure how referrals were communicated from the dentist. Attempts to contact the facility's dental provider were unsuccessful. During an interview with the Director of Nursing (DON) on 12/5/19 at 12:15 PM she expressed that prior to her arrival at the facility earlier in the year there was no consistent system in place at the facility for processing dental referrals or recommendations. She stated the dental note should have been given to the Supply Coordinator so a referral could have been made for oral surgery. The DON explained that the facility now had a system in place and any consultant notes were left at the nurse's station and any indicated referrals were given to the Supply Coordinator for follow up.	F 791	The Transportation Director will meet with the Contracted Dental Provider when in facility and collect any consultations and referrals to be processed at that time. All findings will be reported to the QAPI committee monthly on-going by the Transportation Director. If any issues are identified, they will be addressed at this time.	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)	F 803		1/9/20

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F 803	Continued From page 24 §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, review of the planned menu and staff interviews the facility failed to serve the menu as planned for 2 of 2 meal observations. Findings included: 1.A review of the dietary menu for the week of 12-1-19 revealed the residents were to receive bread dressing on 12-1-19 for lunch with savory pork roast, broccoli and dinner roll.	F 803	F803 Menus Meet Resident Needs/Prep in Advance/Followed Facility failed to serve menu as planned and directed by the Dietician. All Patients have the potential to be affected by this deficient practice. The Interim Food Service Director failed	

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F 803	Continued From page 25 During an observation of the lunch meal on 12-1-19, the residents had not received bread dressing but were served sweet potatoes. The observation also revealed that the menu provided to the residents did not have the substitution listed. The dietary supervisor was interviewed on 12-5-19 at 9:50am. The dietary supervisor stated he was informed by the cook "at the last minute" that the bread dressing was not available, so he substituted the bread dressing with sweet potatoes. He also stated he had not written the substitution down on their substitution log and that he was unaware the dietician needed to be informed when a substitution was made on the menu. 2. Another review of the dietary menu for the week of 12-1-19 revealed residents were to receive stewed tomatoes and hash browns along with vegetable quiche for their dinner meal on 12-4-19. An observation of the dinner meal occurred on 12-4-19 at 5:30pm. During the observation it was noted that the serving line ran out of the stewed tomatoes and hash browns. The line server was noted to substitute the stewed tomatoes with corn and the hash browns with wedge potatoes. The dietary supervisor was interviewed on 12-5-19 at 9:50am. The dietary supervisor stated he was not informed by the staff on the serving line they had run out of the stewed tomatoes and he had more stewed tomatoes available. He also stated he was not aware the line staff substituted the stewed tomatoes with corn. The dietary	F 803	to order enough food for service of planned menu. The Interim Food Service Director served food that was available at the time as a substitute. Facility Full-time Certified Dietary Manager returned from leave on 12/30/2019. Full-time Certified Dietary Manager will review all food orders on a weekly basis to ensure food items are available and facility does not run out of planned items. The Administrator and Certified Dietary Manager (CDM) educated the dietary staff on 1/6/20 on following menu requirements as it relates to daily food service. Specifics of education related to notification of menu change, authorization procedures for substituting items not available on the menu reference to substitution log. Additional education was provided that residents have to be notified regarding substitution changes. An audit tool will be used to validate that the meal being serviced matches the menu. It will also indicate whether or not substitutions were needed and if they were approved. This tool will be monitored by the CDM/designee daily x 2 weeks, twice weekly x 3 weeks; once weekly x 4 weeks and monthly on-going. All findings will be brought to the QAPI committee monthly by the CDM on-going. If any issues are identified, they will be addressed at this time.	

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F 803	Continued From page 26 supervisor stated he was aware of the hash browns running out "that is why I made the wedge potatoes". He also stated he had not written the substitution down on their substitution log and he was unaware the dietician needed to be informed when a substitution was made on the menu. During an interview with the Administrator, Director of Nursing and regional nurse on 12-5-19 at 2:00pm, the regional nurse stated the Dietary Director was out on leave and she had attempted to prepare and train the dietary supervisor "as much as she could but could not get to everything". She also stated she did not know what the Dietary Director was able to train the dietary supervisor on prior to leaving but would speak with the dietary supervisor.	F 803		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to follow the therapeutic menu for liberal renal diets. This was evident in 1 of 1 observation. Findings included:	F 808	F808 Therapeutic Diet Prescribed by Physician Facility failed to follow therapeutic menu for renal diets. This was evident in 1 of 1 observation.	1/9/20

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F 808	Continued From page 27 A review of the facility's menu for 12-4-19, the dinner meal, revealed the residents who were ordered liberal renal diets should have received a baked omelet, rice and sliced carrots. During an observation of the dinner meal on 12-4-19 at 5:30pm, the observation revealed the residents on a liberal renal diet received vegetable quiche, hash browns and stewed tomatoes. The dietary cook was interviewed on 12-5-19 at 9:40am. The dietary cook stated there were 5 residents on liberal renal diets and she prepared food for the renal diets by following the menu spreadsheet. She also stated if there were substitutions to the menu, she had to write the substitution in a log so it could be reviewed by the dietician. The cook stated she did not know why the residents on a liberal renal diet were served food that was not part of their diet. The dietary supervisor was interviewed on 12-5-19 at 9:50am. The supervisor stated he was not aware that the liberal renal residents could not receive stewed tomatoes and there was rice on the steam table for the renal diets, but was not aware the line staff had not provided the correct foods. He also stated he had prepared a quiche with no cheese or broccoli for the renal residents but was not aware the residents received the vegetable quiche "I was being pulled in a lot of different directions last night and did not notice". During an interview with the Administrator, Director of Nursing and regional nurse on 12-5-19 at 2:00pm, the Administrator stated the Dietary Director was out on leave and the dietary supervisor was "doing the best he can". The	F 808	All patients receiving therapeutic diets have the potential to be affected by this deficient practice. The facility currently has 4 renal diet patients. Dietary Staff were educated on 12/5/19 by Interim Dietary Manager to ensure they follow the spreadsheet for all therapeutic diets including renal. Once identified on 12/5/2019, alternative food items appropriate for renal diets were offered to renal patients. All Dietary Staff were educated by the Administrator /Certified Dietary Manager (CDM) on 1/6/2020 to ensure staff follow the menu for therapeutic diets, including renal patients diets as evident by reference to dietary spreadsheet. Additional educational topics were related to who has authority to change spreadsheet. An audit tool will be used to validate therapeutic diet compliance. The CDM/designee will audit to ensure therapeutic diets are being followed daily x 2 weeks; twice weekly x 3 weeks; once weekly x 4 weeks and monthly on-going or until substantial compliance is achieved. All findings will be brought to the QAPI committee monthly by the CDM on-going. If any issues are identified, they will be addressed at this time.	

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F 808	Continued From page 28 Administrator also stated he did not believe the errors were a systemic problem "we do the best we can when employees go out o leave".	F 808		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain clean dishware and allow cook ware to air dry before stacking them for use on the tray line. This was evident in 2 of 2 kitchen observations. Findings included: 1.During the initial tour of the kitchen on 12-1-19 at 10:15am with the dietary supervisor revealed the following:	F 812	F812 Food Procurement Store/Prepare/Serve under Sanitary Conditions. Facility failed to maintain clean dishware and follow approved and established cleaning and drying procedures as evident by food particles being present in plate warmers and plastic bowls. 10 plate lids were also noted to be stacked wet together.	1/9/20

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F 812	Continued From page 29 a. There were 9 bottom plate warmers stacked wet. b. 1 of 9 bottom plate warmers had food particles along the rim c. 6 plastic bowels had dried food particles in them. d. 7 six-inch-deep steam table pans were stacked together wet. e. 5 metal steam table lids were on a shelf with grease, dust and food particles on them f. 10 plate lids were stacked wet g. 1 of 10 plate lids had food particles on the inside of the lid. The dietary supervisor was interviewed on 12-1-19 at 10:30am. The supervisor stated he had been "filling in" for the dietary manager who was out on leave. He also stated the kitchen staff was not waiting for the cookware and dishes to dry before stacking them "we have drying racks, but they must be removing them to soon". 2. A second observation of the kitchen was made on 12-4-19 at 5:00pm and revealed the following: a. There was 1 dirty bottom plate warmer with food particles around the rim on the tray line ready to be used. b. 4 of 5 bottom plate warmers were noted on the tray line with large sections broken off leaving sharp plastic pieces around the rim.	F 812	All Patients have the potential to be affected by this deficient practice due to dietary staff not following appropriate cleaning and drying procedures. The bottom plate warmer, 6 plastic bowls, 5 steam table lids and identified plate lids containing food particles were immediately cleaned and sanitized by dietary aides and allowed to properly air dry on 12/1/2019. The Administrator educated Dietary Staff on 12/4/19 regarding appropriate drying procedures. Dietary staff immediately cleaned the area identified to be not under sanitary conditions on 12/4/2019. Broken Dishware was immediately discarded by the Interim Certified Dietary Manager. The Certified Dietary Manager/Administrator educated the staff again on 1/6/2020 on proper sanitation procedures for food service safety, dishwashing procedure and air drying procedures. An audit tool be used and monitored by the Administrator/ Certified Dietary Manager to validate dishware is clean and dry and no broken dishware is noted in kitchen area and if food particles are present in bowls/warmers. The Administrator/Certified Dietary Manager (CDM) will audit correct drying procedures and observe for food particles in plate warmers and on steam table daily	

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F 812	Continued From page 30 The dietary supervisor was interviewed on 12-4-19 at 5:25pm. The supervisor stated he thought had "removed them from the line". During an interview with the Administrator, Director of Nursing and regional nurse on 12-5-19 at 2:00pm, the Administrator stated the Dietary Director went out on leave 2 weeks ago and was expected back around the end of the month "we are doing the best we can when someone goes out on leave". He also stated management had started education with the kitchen staff on proper storage of equipment.	F 812	x 2 weeks; twice weekly x 3 weeks; once weekly x 4 weeks and monthly on-going or until substantial compliance is achieved. All findings will be brought to the QAPI committee monthly by the Certified Dietary Manager (CDM) on-going. If any issues are identified, they will be addressed at this time	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential	F 842		1/9/20

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F 842	Continued From page 31	F 842		

all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

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F 842	Continued From page 32 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff, resident, and resident representative interviews the facility failed to maintain an accurate Medication Administration Record by 1) documenting administration of eye drops that were not available to be administered for 1 of 1 sampled residents (Resident #111) reviewed for visual deficit, and 2) documenting the application of compression stockings that were not applied for 1 of 1 residents reviewed for pressure ulcers (Resident #27). The findings included: 1) Resident #111 was admitted to the facility on 9-9-16 with multiple diagnoses that included glaucoma and dementia. The physician's orders were reviewed and revealed an order to administer one drop in both eyes at bedtime for Lumigan drops 0.01% for glaucoma that was placed on 10/1/18 and renewed through 6/11/2020. Review of the pharmacy medication records from November 2018 revealed that the resident's Lumigan drops were delivered to the facility on 11/13/18 and the ordered supply would last approximately 25 days. Resident #111's Lumigan drops were not delivered from the pharmacy to the facility again until 8/21/19. The Medication Administration Record (MAR)	F 842	F842 Resident Records- Identifiable Information The facility failed to maintain accurate med administration records by signing out that eye drops were administered when not available and by acknowledging that ted hose were present on a patient when new order for wraps was initiated. The order for ted hose placement was D/C'd by the Director of Nursing (DON) on 12/1/2019 for Resident #27. Corrective Action date to correct the missing Lumigan eye drops for Resident # 111 was on 8/21/2019. The facility ordered Lumigan eye drops were ordered for Resident #111 on 8/21/19 and administered as ordered. The DON/Designee will complete a 100% audit on all patients with orders for prescription medicated eye drops and ted hose to ensure appropriate application and documented when administered. The audit will be completed by 1/8/2020. All patients receiving prescription medicated eye drops and orders for ted hose placement have the potential to be affected by this deficient practice. A 100% audit of all residents receiving Ted Hose	

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F 842	Continued From page 33 was reviewed for December 2018 through August 21, 2019 and revealed documentation that the nursing staff were signing Resident #111 was receiving her Lumigan eye drops as ordered almost daily. During an interview with Resident #111's representative on 12/4/19 at 1:02 PM she stated that she had noticed that the resident's pharmacy bills had not charged for the Lumigan drops for a long time so she had notified the Director of Nursing (DON) in August 2019. During an interview with the DON on 12/4/19 at 2:01 PM she stated that Resident #111's representative had informed her of the resident's eye drops not being on her pharmacy bill August 2019. She had started an investigation at that time and found that the eye drops had not been delivered from the pharmacy from November 2018 until August 2019. The facility's medical director was informed of the error and had examined the resident. The DON stated that during assessments of Resident #111, there was no indication she was in pain, and that due to her cognitive impairment it was impossible to ask her questions about vision changes. She stated she was monitoring the resident's MAR and delivery dates of her eye drops to ensure she was getting them as ordered. During an interview with Medication Aid #5 on 12/05/19 at 1:50 PM she stated that she may have documented the Lumigan eye drops as given, couldn't find the drops, and forgot to change it. She stated she had documented a few	F 842	or medicated eye drops were checked by Nursing Administration. This audit was completed on 1/9/2020. The audit for Ted Hose was to ensure they are placed per order, signed off correctly and if not needed D/C'd. The audit for eye drops was to ensure all residents are receiving them as ordered, they have the correct bottle of drops, they are being given as ordered and re-ordered if needed. The DON/designee will compare the resident roster for residents receiving medicated eye drops against the monthly pharmacy billing statement to ensure eye drops are being refilled monthly as ordered. The treatment nurse will monitor weekly all residents that have Ted Hose orders are wearing them and if a new treatment for their legs is ordered she will discuss with MD and will D/C the Ted Hose order. Monthly cart audits will be completed by the pharmacy to ensure eye drop bottles are there for each resident taking medicated eye drops. Monthly EMAR check with be conducted by the DON/Designee to ensure the pharmacy cart audit and pharmacy bill coincide. The Nurses and Med Aides were educated by Staff Development Coordinator and completed on 1/6/2020 to verify that ted hose are in place as directed by Physician Order. The education will be conducted on orientation and annually thereafter. The Staff Development Coordinator educated all Nurses and Med Aides and completed on 1/9/2020 to include eye	

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F 842	Continued From page 34 times that the medication wasn't available. She stated that if the medication was not available to be given, her documenting it was given was an error. When asked if she had been informed or educated about her documentation errors by the DON or administrative staff, she stated that she had not. During an interview with Nurse #7 on 12/05/19 at 2:01 PM she stated that if there was documentation that the Lumigan drops were given when it was not available to be given, it was an oversight and an error. When asked if she had been informed or educated about her documentation errors for this particular situation for Resident #111 by the DON or administrative staff, she stated that she had not been informed of the errors she had made regarding the documentation of administration of eye drops that were not available to be given. 2.Resident #27 was admitted to the facility on 8-3-18 with multiple diagnosis that included acute post hemorrhagic anemia, Parkinson's, congestive heart failure and dysphagia. The quarterly Minimum Data Set (MDS) dated 10-6-19 revealed Resident #27 was moderately cognitively impaired and needed assistance with one person for his activities of daily living. Resident #27's care plan dated 11-11-19 revealed goals and interventions for skin care and activities of daily living. The physician's orders dated 10-22-19 were reviewed and revealed an order for compression stocking to Resident #27's left leg daily for edema (swelling).	F 842	drop administration and process for reordering medications. Further education included the 6 rights of medication administration. This education will be conducted on orientation and annually thereafter. The mandatory in-services focused on the 6 rights of medication administration was completed on 1/9/2020 and included proper procedure for documentation of missing medication, how to reorder medication, and to notify the nursing supervisor if medication has not arrived from the pharmacy. To visualize TED hose are on the resident before documenting in the EMAR, and if Ted Hose are not in place, ascertain why and make adjustments as needed. Never document your initials on a medication not given or Ted Hose that you have not visualized on the resident. Each nurse and med aide found to have the deficient practice has attended mandatory education, taken and passed a test with at least a 95% score. If further violation is found the disciplinary action policy will begin. An audit tool will be used by Director of Nursing (DON)/Designee to ensure ted hose are in place as ordered and medicated eye drops administered as ordered. This audit tool will begin on 1/6/2020 and facility will be in compliance by 1/9/2020. DON/Designee will audit daily x 1 week, 2 x week x 3 weeks; weekly x 4 weeks and monthly ongoing.	

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 12/11/2019

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

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F 842	Continued From page 35 The Medication Administration Record (MAR) was reviewed for November 2019 and December 2019 and revealed documentation that the nursing staff were signing Resident #27 had his compression stockings placed on him daily. Resident #27 was observed lying in bed on 12-1-19 at 2:14pm with his left leg wrapped and no compression stocking present. During an interview with Resident #27 on 12-3-19 at 10:00am, the resident was noted to have his left leg wrapped with no compression stocking present. The resident stated, "I don't have TED hose (compression stocking) I have this on". The resident pointed to his left leg revealing a wrap. Resident #27 also stated he had not had TED hose (compression stocking) since he was at home. During an interview with medication aide #3 on 12-3-19 at 12:35pm, the medication aide stated Resident #27 had an order for compression stockings and the nursing assistant "should have" put them on Resident #27 that morning (12-3-19). She also stated it was the nursing assistant responsibility to place the compression stockings on the resident. Medication aide #3 was interviewed again on 12-3-19 at 12:40pm. The medication aide stated Resident #27 did not have compression stockings "he gets his leg wrapped by the wound care nurse". She also stated, "I guess it is just habit to mark that the compression stockings were put on, but the order should have been discontinued". The wound care nurse was interviewed on	F 842	All findings will be reported to QAPI monthly on-going by the Director of Nursing. If any issues are identified, they will be addressed at this time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842	Continued From page 36	F 842		

12-3-19 at 12:45pm. The wound care nurse stated she was unaware there was an order for compression stockings "I have been wrapping his leg since his admission" and stated she had not seen him with a compression stocking. She also stated the staff nurse working the unit should have discontinued the order for the compression stockings once the order for the left lower leg to be wrapped was entered into the system.

Nurse Practitioner #2 was interviewed on 12-4-19 at 11:10am. The Nurse Practitioner stated the order on the Medication Administration Record for the compression stockings "should have prompted" the nursing staff to request a discontinuation order for the compression stockings since the resident was receiving wraps from the wound care nurse.

During an interview with the Administrator, Director of Nursing and regional nurse on 12-5-19 at 2:00pm, the Director of Nursing stated Resident #27 had been sent out to the hospital in October 2019 and when a resident returned from the hospital staff had to manually discontinue previous orders and update the system with the new orders and that had not occurred. She also stated management had started education with staff on accurate order entry.