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 11/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A unannounced complaint investigation and recertification Survey was conducted on 11/14/22 through 11/18/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # OXQJ11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 11/14/22 through 11/18/22. Intakes NC00194347 and NC00193845 were investigated. 2 of 6 complaint allegations were substantiated. Event ID # OXQJ11.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623		12/6/22

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

Electronically Signed | 12/07/2022

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F 623	Continued From page 1	F 623		

made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related

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F 623	Continued From page 2 disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide written notice of discharge to the ombudsman for 1 of 2 residents reviewed for hospital discharge (Resident #41).	F 623	Education was provided by the Administrator to the social workers regarding notification to the Ombudsman of a resident's transfer or discharge. Completed 12/6/2022.	

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F 623	Continued From page 3 Resident #41 was admitted on 5/2/16 and readmitted on 9/6/22. Resident #41's minimum data set assessment dated 8/2/22 indicated Resident #41 had severe cognitive impairment. Review of nursing note dated 9/3/22 revealed Resident #41 was sent to the hospital emergency department for evaluation. Resident #41 returned from the hospital on 9/6/22. The Social Worker was unable to provide documentation or records providing evidence of communication of the residents discharged to the hospital to the ombudsman. During an interview with the administrator on 11/17/22 at 2:30pm she stated that the social work staff were responsible for issuing the notices of discharge to the Ombudsman. The administrator stated that this has not been done for over a year.	F 623	For the resident affected, written notification of discharge for resident #41 was sent to the Ombudsmen on 12/2/2022. To ensure no other residents were affected Social Work completed an audit of the last 30-day discharges. No others were identified. Completed on 12/2/2022. The Administrator or designee will audit discharged residents for proper notification to the Ombudsman weekly for 4 weeks, then monthly for 3 months. The monitoring began on 12/6/2022. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Administrator monthly for 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by	F 693		11/21/22

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F 693	Continued From page 4 enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the Nurse (Nurse #1) failed to follow procedure for gastrostomy tube (g-tube) care, when she was observed to push water through a syringe into the g- tube, instead of allowing the water to flow in the syringe by gravity through the g- tube to prevent discomfort in the abdomen for 1 of 3 residents reviewed for g- tube care (Resident #28). The findings included: Resident #28 was originally admitted to the facility on 11/12/21 with diagnoses that included hemiplegia, cerebral infarction, dysphagia, gastrostomy status, moderate protein-calorie malnutrition, dementia, hypertension, aphasia, and type 2 diabetes mellitus. The quarterly Minimum Data Set (MDS) assessment dated 9/4/22 indicated Resident #28 had severe cognitive impairment. She was coded as receiving 51% of more of his total calories through a tube feeding and an average fluid intake of 501 cubic centimeters (cc) per day or	F 693	Nurse #1 was educated on G-tube protocol with return demonstration and competency. Completed 11/16/2022. All licensed nurses were educated by the DON/Staff Development Coordinator on G-tube protocol with return demonstration and competency prior to their next scheduled shift. Completed 11/21/2022. All newly hired licensed nurses will receive education on G-tube protocol with return demonstration and competency as part of their orientation. The ADON/SDC will monitor care provided to random residents identified with G-tube placement to ensure adherence to training 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, then monthly times 1 month. The monitoring began on 11/16/2022. Data obtained during the audit process will be analyzed for patterns and trends	

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F 693	Continued From page 5 more by tube feeding. A review of Resident #28's active care plan, last reviewed 7/1/22, revealed Resident was at risk for weight loss due to need for nutrition support via gastrostomy tube (g-tube). Interventions included to give tube feeding as ordered. A review of Resident #28's active physician orders included an order dated 6/24/21 to flush the feeding tube with 200 milliliters (ml) of water daily. On 11/16/22 at 9:34 am, an observation of Resident #28 occurred. Nurse #1 pushed water with a syringe into Resident #28's g-tube instead of allowing the water to flow in the syringe by gravity through the g- tube to prevent discomfort in the abdomen. During an interview with Nurse #1 on 11/16/22 at 9:42 am, she indicated she usually push the fluids through the g-tube. Nurse #1 indicated upon hire at the facility she did not receive g-tube training or perform competency check off for g-tube care. An interview was conducted with the Assistant Director of Nursing (ADON) on 11/16/22 at 9:45 am and she indicated the correct way to flush a g-tube was to allow the water to flow by gravity in the syringe through the tube to prevent discomfort in the abdomen. An observation was conducted on 11/16/22 at 10:04 am with the ADON perform g-tube flush on Resident #28 with Nurse #1 present. The ADON placed water into Resident's g-tube through syringe and allowed water to flow by gravity into g-tube.	F 693	and reported to QAPI by the Administrator monthly for 3 months. At that time, The QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. The DON or designee will monitor new hire education weekly times four weeks, biweekly for four weeks, then monthly for 1 month. Initiated 11/16/2022.	

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F 693	Continued From page 6 On 11/17/22 at 12:54 pm an interview was conducted with the DON, and it was indicated she expected Nurses to follow the correct procedure for g-tube flushing. She indicated she had just started in the facility and a new Staff Development Coordinator was in place and they would be working together to ensure staff were competent and trained prior to working with the residents in the facility.	F 693		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able	F 726		12/16/22

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F 726	Continued From page 7 to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to ensure they had competent nursing staff trained and competent in skills and techniques necessary to care for residents with needs for gastrostomy (g-tube) care for 1 of 1 nurse (Nurse #1) observed for g-tube care. The findings included: A review of the facility assessment indicated competent staff were required to care for residents with feeding tubes. An observation was made on 11/16/22 at 9:34 am of Resident #28 receiving a g-tube flush. Nurse #1 pushed 50 milliliters of sterile water with a syringe through Resident #28's g-tube instead of allowing the water to flow by gravity into her abdomen to prevent discomfort. During an interview with Nurse #1 on 11/16/22 at 9:42 am. Nurse #1 indicated her start date was 10/27/22 and during her orientation or prior to her work assignment she did not receive g-tube training or perform competency check off for g-tubes. A review was completed of Nurse #1's employee file and there were no skills checklist or competencies found. An interview was conducted on 11/17/22 at 12:44	F 726	Nurse #1 was educated on G-tube protocol with return demonstration and competency. Completed 11-16-2022. All licensed nurses were educated by the DON/Staff Development Coordinator on G-tube protocol with return demonstration and competency prior to their next scheduled shift. Completed on 11/21/2022. All current nursing staff without documented basic nursing skills checklist and competencies will be reeducated and a copy of their skills checklist and competencies will be placed in their employee file. Completion date 12/16/2022. All newly hired licensed nurses will complete and be provided education on basic nursing skills with competency check off during their orientation period to include G-Tube protocol. Initiated 12/16/2021. DON or designee will monitor the completion of skills checklist and competencies of new employees weekly times 4 weeks, then biweekly for 1 month, then monthly times 1 month. This monitoring began on 11/17/2022.	

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F 726	Continued From page 8 pm with the Assistant Director of Nursing (ADON) and she indicated she helped with the orientation process before and would be helping the new Staff Development Coordinator (SDC). She indicated after Nurses received general orientation, they then were setup with someone that should be with them on the floor for at least 3 days and should be checked off with the orientation skilled checklist, which included basic nursing skills. The ADON indicated the person that is assigned to train the new hire was responsible for ensuring the checklist was completed and returned to the SDC. She indicated she was not aware that some Nurses did not have skills checklist check offs or competencies. On 11/17/22 at 12:54 pm an interview was conducted with the Director of Nursing (DON), and it was indicated she was not aware Nursing staff did not have basic nursing skills check offs and competencies prior to working with residents. The DON indicated she had just started in the facility and a new SDC was in place, and they would be working together to ensure staff were competent and trained prior to working with the residents in the facility. An interview was conducted on 11/18/22 at 2:19 pm with the Administrator and she indicated she was not aware that Nursing staff did not have basic skills nursing check offs and competencies, but it was her expectation that they did.	F 726	Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Administrator monthly for 3 months. At that time, the QAPI committee will evaluate the effectiveness of interventions to determine if continued auditing is necessary to maintain compliance.	
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under	F 727		12/9/22

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F 727	Continued From page 9 paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have a Registered Nurse scheduled for 8 consecutive hours a day for 2 (10/30/22 and 11/13/22) of 30 days reviewed. Findings included: A review of the Nursing schedule dated 10/14/22 through 11/14/22 revealed no scheduled Registered Nurse (RN) on 10/30/22 and 11/13/22. Review of the timecards and RN scheduled staffing assignment sheets revealed the facility had no documentation of an RN present in the facility on 10/30/22 and 11/13/22 to meet the requirement for an RN at least 8 consecutive hours per day on each day. During an interview conducted with the Scheduler on 11/16/22 at 9:30am she stated there should have been an RN scheduled every day. The scheduler indicated the Staff Development Coordinator (SDC), was the RN in the facility and was not named on the staffing assignment sheets, from 10/14/22-11/14/22. She stated she	F 727	The Regional Manager provided education to the Administrator and DON on the requirement of utilizing the services of an RN to oversee care and services and provide care as needed at least 8 consecutive hours a day, 7 days a week. Completed on 12/6/2022. Salaried RNs will provide a written time sheets for hours worked. Completed 12/9/2022. The Administrator will monitor daily staffing to ensure RN coverage daily times 2 weeks, weekly times 4 weeks, then monthly times 1 month. This monitoring began on 11/28/2022 Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Administrator monthly times 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is	

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F 727	Continued From page 10 had knowledge an RN needed to be present daily in the facility. An interview was conducted with the Payroll Staff on 11/18/22 at 2:55pm. The Payroll Staff could not verify there was RN coverage for at least 8 hours on 10/30/22 and 11/13/22. The Payroll Staff confirmed the SDC did not work those dates. An interview was conducted with the Director of Nursing on 11/18/22 at 3:10 pm. She stated she expected the facility to have an RN staffed to meet the regulation for 8 consecutive hours a day, 7 days a week. During an interview conducted with the Administrator on 11/18/22 at 3:30pm she stated she expected the Scheduler to staff an RN for 8 hours per day, 7 days a week.	F 727	necessary to maintain compliance.	
F 867 SS=B	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey dated 03/17/21. This was discovered for one deficiency	F 867	The Facility Quality Assurance Committee failed to maintain implemented procedures and monitor the inventions the facility put into place following the recertification and complaint survey dated 3/17/2021 in the area of F623 requirements before Transfer/Discharge.	12/9/22

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F 867	Continued From page 11 cited in the areas of discharge. A discharge deficiency was cited again on the recertification and complaint survey dated 11/18/22. The repeated citations during the two surveys of record shows a pattern of the facility's inability to sustain an effective QAA program Findings included: This tag is cross referenced to: F623: Based on record review and staff interviews the facility failed to provide written notice of discharge to the ombudsman for 1 of 2 residents reviewed for hospital discharge (Resident #41). During the recertification and complaint survey dated 03/17/21 the facility failed to notify the resident's responsible party of the resident's discharge in writing for 1 of 3 residents reviewed for discharge who were discharged from the facility to home. An interview with the Administrator was conducted on 11/18/22 at 4:35 pm. She revealed that her expectation was for the team to work together to sustain an effective Quality Assurance Performance Improvement Committee to ensure the facility does not repeat a previous deficient practice. The Administrator indicated her goal for the facility was to not receive any more repeat tags.	F 867	A plan of Correction for F623 cited during the survey and complaint investigation on March 17th, 2021 was submitted and approved with follow up and return compliance visit. Plans of correction were put into place at the time the deficiency was cited. The plan of correction included monitoring tools, and review of monitoring tools during monthly Quality Assurance Committee meetings for a defined amount of time. Monitoring of the plan of correction was presented to the Quality Assurance Committee and no further issues were identified throughout the monitoring period and were discontinued. The Administrator initiated an in-service to all administrative staff on December 7, 2022 regarding Quality Assurance Performance improvement processes including identifying and prioritizing quality deficiencies, systemically analyzing causes of systemic quality deficiencies, developing and implementing corrective action or performance improvement activities and monitoring and evaluating the effectiveness of corrective action/performance improvement activities. This in-service included ensuring accuracy of audits, extending audits when appropriate, and reviewing corrective action/performance improvement activities to evaluate the effectiveness of each plan and revise, as necessary. All newly hired administrative staff will receive the appropriated education during orientation. No	

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 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 12	F 867	Administrative staff will work until they have received the appropriate education. The QAPI Committee will review the compliance audits for F623 to evaluate continued compliance. The committee will make recommendations if any noncompliance is identified and reevaluate the plan of correction for possible revision. The process will continue until the facility has achieved three months of consistent compliance. The Administrator will be responsible for the plan of corrections. Date of Compliance12/9/2022	