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 01/23/2023

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
F 000	INITIAL COMMENTS A complaint investigation and follow up survey was conducted from 1/17/23 through 1/23/23. Event ID# 65M011 and OXQJ12. The following intakes were investigated NC00195636 , NC00196305, NC00196440, and NC00196900. 2 of the 7 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to implement their abuse policy in the area of investigation by not interviewing Nursing Assistant #1 who provided care to the resident on alleged abuse dates (Resident #1) for 1 of 3 residents reviewed for abuse.	F 610	On 02/07/2023, The Regional Operations Manager educated the Administrator on investigating an abuse allegation and documentation. On 02/07/2023, the Regional Operations	2/8/23

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

Electronically Signed | 02/07/2023

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F 610	Continued From page 1 The findings included: Review of the facility policy titled "Abuse" dated 10/2022, read in part: "Section III, Procedure: C. Investigation 2. Documentation of the investigation findings is maintained on applicable forms or reports. 6. Activities conducted in the investigative process include, at a minimum: a. Review of the following: iii. Personnel records if an employee(s) is suspected or accused. b. completion of the following interviews: ii. (d) Staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. 7. General guidelines for interviewing that are to be incorporated in an investigation include: d. Witness reports are documented in writing by the investigator and signed and dated by both the interviewer and witness." The facility had an allegation of sexual abuse and submitted an initial report of abuse on 11/22/22 and their investigation on 11/25/22 when there was a transmission error. The investigation was resubmitted on 12/8/22 successfully. A review of the facility reported incident (FRI) at 24 hours and 5 days documented an investigation for allegation of sexual abuse. The resident alleged that a male nursing assistant inappropriately touched her vagina either on 11/17/22 or 11/18/22 which was reported on 11/22/22. The facility's investigation report dated 11/25/22 indicated they first became aware of the incident on 11/22/22. Resident #1 told Nursing Assistant (NA) #6 that there was a sexual pervert. The NA informed Social Work (SW) and the Administrator. SW interviewed the resident who	F 610	Manager, reviewed all allegations of abuse for the previous 3 months to ensure investigations were completed thoroughly. Any concerns identified were corrected and education provided. Completion 02/08/2023. The Administrator was educated on 02/07/2023 by the Regional Operations Manager on complete documentation of transmissions of documentation, interviewing and investigation on abuse. The Regional Operations Managerwill review all allegations of abuse for the next 3 months to ensure, the investigation and documentation is complete. The Regional Operations Manager will submit the audit results to the Facility Quality Assurance Committee Meeting monthly x 3 months. At that time, The Quality Assurance Committee will determine if further monitoring will be needed.	

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F 610	Continued From page 2	F 610		

shared the alleged perpetrator was a male staff who provided care to her. SW reported her findings to the Administrator. The Administrator and DON interviewed Resident #1 and received more information from the resident and determined the incident happened on 11/17/22 or 11/18/22. The NA was a male that had provided care 3 or 4 times before. The resident was taken to another room (other than the resident's room) to be prepared for bed. The time was approximately 8:00 pm. When asked the last time the NA was seen, the resident responded doing laundry. The resident stated the NA was Cuban and talked normal. Staff members that took care of the resident from 7:00 am to 11:00 pm were females on 11/17/22 and 11/18/22. The psychiatric Nurse Practitioner (NP) interviewed the resident and found there were inconsistencies with the resident's account of the incident. The allegation was unsubstantiated.

On 1/18/23 at 1:41 pm an interview was conducted with the Social Worker (SW). SW stated she was informed of the abuse allegation from NA #6 but could not remember the date. She interviewed Resident #1 and reported back to the Administrator and Director of Nursing (DON). The SW was not aware that a male NA (NA #1) was assigned to Resident #1 and provided incontinence care on 1/17/22 and 1/18/22 night shift.

The Administrator provided a type-written interview of Resident #1 on 11/22/22 which was not signed. The resident recognized the man who touched her as he was walking by in the hall and he provided care on 11/17/22 and 11/18/22. This man had provided care 3 or 4 times before. The touching incident did not happen in her room.

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It was in a room that had a table and was barren (of furniture). The resident stated the man was Cuban. The resident could not describe the staff member.

During an interview with the Administrator on 1/18/23 at 2:40 pm, the Administrator provided the hand-written list of nursing staff on schedule for 11/17/22 and 11/18/22 which totaled 18 for all 3 shifts that she interviewed in response to Resident #1's allegation that she was inappropriately touched by a male nursing assistant. She stated that the staff were asked if the resident reported any abuse or anything unusual to them and all answered no. The interviews were not documented. She concluded none of the nursing staff were a suspect of the allegation nor were they asked what happened with care provided to the resident. The resident's activity of daily living record was not reviewed to determine who provided care.

A review of the nurse staffing schedule for 11/17/22 and 11/18/22 documented NA #1 was listed on 11/17/22 and not on 11/18/22.

A review of Resident #1's incontinence care documentation revealed NA #1 electronically signed he provided care to the resident on 11/17/22 and 11/18/22.

The Administrator went on to say that NA #1 was not on the 11/18/22 schedule and worked night shift so he could not have been a suspect because the resident alleged the abuse occurred about 8:00 pm on 11/17/22 or 11/18/22 and NA #1 worked nights (11:00 pm to 7:00 am). The resident was cognitively intact and would know what time this allegation occurred. The

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F 610	Continued From page 4 Administrator then went on to say that the resident had paranoia and a history of hallucination, and her story was inconsistent. The Administrator further stated that NA #1 never had a problem, was a male, and had an accent, but it was African. The Administrator stated she was not aware the resident had cognitive communication deficit and was not aware that NA #1 (male) was on staff both 11/17/22 and 11/18/22 night shift assigned to the resident and provided incontinence care both nights. The Administrator stated that NA #1 resigned shortly after the abuse allegation investigation by the police.	F 610		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record and manufacturer's instruction review, and staff interviews, the facility failed to assess the resident for safe mechanical lift transfer by one person (Resident #2) for 1 of 2 residents reviewed for accidents. The findings included: Resident #2 was admitted to the facility on 8/6/21 with the diagnoses of muscle wasting and	F 689	On 01/09/2023, Physical Therapy Assistant(PTA) was educated by the Therapy Director that all Hoyer Mechanical Lift transfers must be done by two persons. Resident #2 was not affected by this deficient practice. The PTA was interviewed on 01/09/2023 by the Therapy Department and reports that he has not transferred any other residents in a lift with one person.	2/8/23

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F 689	Continued From page 5 quadriplegia. Resident #2's care plan dated 8/6/21 documented the resident was at risk for falls and was dependent for mobility and transfer. Resident #2's readmission from the hospital Minimum Data Set dated 11/24/22 documented an intact cognition and feeling tired 7-11 days out of 14 days. The resident was transferring dependent of 2 staff and bed mobility dependent of 1 staff. The resident's diagnosis was quadriplegia and muscle wasting. On 1/17/23 at 3:25 pm an observation was done of Resident #2 in his room. Upon entry to the room, it was observed that Resident #2 was in the sling hanging being transferred from his wheelchair to his bed by mechanical lift by the Physical Therapy Assistant (PTA). (A PTA follows a plan developed for the resident by the Occupational or Physical Therapist). Concurrent interview: The PTA stated he assisted the nursing staff to transfer the resident to the bed when they are busy. Nursing mechanical lift transfers the resident with 2 persons. He stated that he used 2 people to transfer the resident by mechanical lift when the resident was being transferred out of the bed into the wheelchair because the wheelchair was narrow and if the resident swings he cannot aim onto that narrow surface (of the wheelchair). The PTA stated that he transferred the resident alone (1 person) when getting him back into the bed from the wheelchair because the bed was wider and if the resident swings he could aim easily. "It was easier." He further stated that "nursing does not do this" (one person transfer). The PTA commented that he had been doing the transfer this way with Resident #1 and	F 689	All therapy and nursing staff were reeducated by the Therapy Department, Director of Nursing or designee that all Hoyer Mechanical Lift transfers must be done by two persons. Any nursing staff or therapy staff who did not receive this education by 02/08/2023 will not be allowed to work until this education is completed. The education will be added to the new hire education by the Director of Nursing on 02/08/2023. The Director of Nursing or designee will conduct observations 3 assisted Mechanical lift transfers weekly x 4 weeks, than 1 weekly x 4 weeks then 1 monthly x 1 month. The Director of Nursing or designee will bring the results of the audit to the monthly Quality Assurance Committee Meeting x 3 consecutive months. The Quality Assurance Committee will determine if further auditing will be needed.	

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F 689	Continued From page 6	F 689		

had no problems. He made the decision to transfer the resident by himself.

On 1/17/23 at 3:40 pm an interview was conducted with the Therapy Director. The Therapy Director stated she was familiar with Resident #2 and that he had the diagnosis of quadriplegia and required a mechanical lift transfer to get out of bed. The mechanical lift procedure was normally two-people assisted into and out of the bed. The Therapy Director stated that a two-people transfer was safer for this resident because he is large and dead weight and would be a risk. The therapy plan for the resident did not include mechanical lift transfer by one person. The resident was not evaluated for a one-person transfer by the PTA. She further stated that she would provide one-on-one education to the PTA to transfer this resident by mechanical lift with two staff members for safety. The PTA was an assistant to the therapy staff and the decision to transfer 1 person was not discussed with the Therapy Department for Resident #2. She stated there was a fall risk.

On 1/17/23 at 4:10 pm an interview was conducted with the Administrator. She was not aware that the PTA had transferred Resident #2 by mechanical lift by himself (1 person). No further comments were made.

On 1/17/23 at 4:20 pm the manufacturer's instructions consisting of 27 pages for use of the facility's mechanical lift was provided by the Administrator. The manufacturer's instructions were reviewed which recommended 2 people for mechanical lift transfer. For 2 people: one manages the controls, and one guides the resident. All 10 example pictures on how to

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F 689	Continued From page 7 operate the mechanical lift had 2 people. There was a warning example use of 1 person that the situation would need a health care professional evaluation for each individual case and to use caution. There were no instructions on how to use the mechanical lift with 1 person. Concurrent interview with the Administrator: She stated she was not aware that the Therapy Director wanted the PTA not to use the mechanical lift transfer alone, there should be 2 people. No further statements were made. On 1/18/23 at 3:25 pm an interview was conducted with the Therapy Director. She stated Resident #2 was not a good candidate for a one-person use of the transfer device because of his quadriplegia and muscle wasting and that 2 people would be safer and would provide education to the staff. A decision to make a mechanical transfer one person would have had to be evaluated by the Therapy staff: Physical or Occupational Therapist.	F 689		