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 05/29/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to administer pain medication in a timely manner as ordered by a physician for 1 (Resident #1) of 3 residents reviewed for medication orders. The findings included: Resident #1 was admitted to the facility on 3/11/2016 for rehabilitation services following a joint replacement surgery. The admission minimum data set assessment dated 3/18/2016 coded the resident as being cognitively intact. The resident was coded as being on a scheduled pain medication regimen as well as receiving pain medication on an as needed basis. The frequency of pain was coded as almost constantly. Resident #1 was receiving physical therapy services. The resident's care plan dated 3/21/16 stated, "Resident has constant pain r/t (relative to) his right total knee replacement." One of the interventions stated, "Administer pain medication as requested/ordered. Document effectiveness."	F 309	Submission of the response to The Statement of Deficiencies by the undersigned does not constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is required. F(309)SS=D Specific action taken to correct the deficiency: The corrective actions accomplished for the resident found to be affected by the deficient practice as follows: Resident #1 was discharged from the facility 4/1/2016. All nurses and CNAs were in-serviced on communicating complaints of pain to the assigned nurse in a timely fashion by Staff Development Coordinator "SDC" (and/or designee). All licensed nurses were educated to monitor all residents that have had total joint replacement surgeries and are on pain medications per doctors orders. The CNA is to communicate any	6/26/16

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

Electronically Signed | 06/16/2016

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F 309	Continued From page 1 The resident had physician's orders for "Morphine 30 mg S-R take (1) tab po (by mouth) q (every) 12 hrs (hours)." This was documented on the medication administration record as given at 2000 on 3/19/2016. The resident also had physician's orders for "Percocet 10/325 mg (2) po q 4 h (hours) prn (as needed) pain." This is documented on the medication administration record as given two times on 3/19/2016 by the nurse that worked 7:00 AM to 7:00 PM. The nursing notes for 3/19/2016 documented the prn pain medication was given at 9:45 AM and 2:30 PM. The medication administration record stated, "Pain score assess for pain every shift using pain scale of 0-10." The resident's pain score for the 3-11 shift on 3/19/2016 was coded as a "6." The resident's pain score for the 11-7 shift on 3/19/2016 was coded as a "6." Resident #1 was interviewed on 5/29/2016 at 9:30 AM. The resident stated that on the evening of 3/19/2016 he was in pain. He knew that he had scheduled pain medications to be given as well as pain medication on an as needed basis. He said that at 6:00 PM he asked the nurse aide to tell the nurse he was in pain and would like medication. He stated the nurse did not come to his room. He again asked for pain medication at 8:00 PM. He stated that the nurse aide told him the nurse was coming down the hall with the medication cart and would soon be at his room. At 10:00 PM he said he had not been offered his scheduled evening medications. The nurse aide told the resident that the male nurse was almost to his room. He said he waited but he realized it was close to midnight and he had not received his medications. He said got out of bed and walked down to the nurse's station and found a female nurse had replaced the male nurse that	F 309	reported or observed signs and symptoms of pain to the assigned nurse and/or Supervisor immediately. When the CNA reports pain to the assigned nurse, the nurse will assess the patient and determine if a scheduled or PRN pain medication is to be offered according to doctors orders. The CNA will communicate this by using the STOP and WATCH form and will also share the complaint of pain verbally to the nurse. When the nurse receives the complaint, the nurse will assess the patient. The nurse will review the orders and offer medications and/or non-pharmacological interventions as per doctor or NP orders (or obtain an order from the doctor if needed). The nurse will later return and re-assess if the pain medication or alternatives were effective and document as per protocols. Measures to be put into place or systemic changes made to ensure that the deficient practice will not occur: All residents who have had joint replacement surgery and/or have pain medications ordered were reviewed by the QA Coordinator (or designee). Any MAR that triggered for pain medication was audited by the QA Coordinator. All nursing staff were in-serviced about timely communication about pain from a patient with total joint replacement. All nurses and CNAs were in-serviced about pain and ensuring it is routinely monitored via the pain scale tool and that it is communicated to the nurse immediately.	

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F 309	Continued From page 2 was on duty. He asked the female nurse for his medication for the evening and he said he complained that he was never given his medication. He said by the time he had walked back to his room the female nurse was there to give him his pain medication. He said, "It really bothered me that he (male nurse) just left me hanging. At the time I was in extreme pain. I am a patient and I expect a certain level of care. I was pretty ticked off." The resident stated he wrote a written complaint and gave it to the Director of Nursing when she returned on Monday morning. He stated that the Director of Nursing never gave him any further information regarding his written complaint. An interview was conducted on 5/28/2016 at 8:15 PM with the male nurse that passed medications on the hall of Resident #1 on the evening of 3/19/2016. He stated that he had worked 16 hours that day due to a nurse that was unable to come to work. He said he took over for the nurse that was unable to come to work and began passing the evening medications at 8:30 PM on the hall of Resident #1. The nurse acknowledged that he had not reached the room of Resident #1 by 11:00 PM. He said another nurse came to relieve him at 11:00 PM. He said he passed on to the oncoming nurse that Resident #1 had not yet received the ordered evening medications and went home. The nurse did not recall the aides coming to him to tell him Resident #1 was requesting pain medication while he was passing medications that evening. The nurse stated he was told of the complaint made by Resident #1 by the former Director of Nursing but by that time the resident had already been discharged. A nurse aide that worked from 3:00 PM to 11:00	F 309	The QA Coordinator audited all MARS and identified those who may be affected by the deficient practice. Other patients having the potential to be affected by the same deficient practice were identified and the following corrective action was put in place. The licensed nurse is to monitor all patients that have pain medications on each shift. Once the nurse is notified of any verbal or non-verbal complaints of pain, the nurse is to evaluate the patient and offer medications as ordered an/or non-pharmacological interventions (i.e. ice, repositioning as appropriate)and re-evaluate for effectiveness and document in the appropriate places (front and back of MAR). All CNAs were in-serviced by SDC about how to communicate pain complaints to the nurse. The CNA will use verbal and written communication. The CNA will document this communication on the kiosk each shift and use the STOP and WATCH form. This will be monitored by the Shift Supervisors and the nurses who do 24 hour chart checks until we are online with the eMARs System (Sept 2016 approximately). Once we utilize the eMAR System the program will alert the nurse as to time frames for pain medications. An indicator in the eMAR system will flag that the medication is due, and/or is still within the time frame allowance and/or is past due or requires re-assessment. Acute patients will also be reviewed in report via the 24hr report. QA will review approximately 25% of those identified through random audits of	

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F 309	Continued From page 3 PM on 3/19/2016 on the hall of Resident #1 was interviewed on 5/28/2016 at 8:35 PM but she did not recall the resident or that evening. The other nurse aide that was scheduled as working on 3/19/2016 on the hall of Resident #1 was not available for an interview. The former Director of Nursing was not available for interview at the time of the investigation. The facility administrator was interviewed on 5/29/2016 at 11:00 AM regarding the events of 3/19/2106 and Resident #1. She stated, "My expectation would be that the CNAs (certified nursing assistants) pass on the information to the nurse, the nurse go and assess the resident, and pass medications as ordered."	F 309	the Short Term Rehab patient medication administration records for effective pain management weeklyx4, then monthlyx2, and quarterlyx2. Patient Satisfaction Surveys and grievances will be monitored monthly in QA meetings for pain management.	