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	345547	A. BUILDING _____ B. WING _____	C 11/16/2018

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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §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 staff interviews and record review the facility failed to accurately code a prognosis of less than six months (section J) on the comprehensive Minimum Data Set (MDS) assessment for 1 of 1 resident (Resident #23) reviewed for Hospice services. Findings included: Resident #23 was admitted to the facility on 5/25/18 with diagnoses that included, in part, gangrene right foot and malnutrition. A review of the medical record revealed Resident #23 was admitted to Hospice services on 9/14/18. A review of the comprehensive MDS assessment dated 9/27/18 revealed the resident received Hospice services. Further review of the MDS assessment revealed a prognosis of less than six months (section J) was not checked. On 11/15/18 at 3:48 PM an interview was completed with MDS Nurse #1. She said a significant change in status assessment was completed on Resident #23 because she was admitted to Hospice services. She acknowledged the prognosis section (section J) was not checked because she had not yet received a statement from the physician that the resident had six months or less of life expectancy. She stated that typically once the physician signed the	F 641	The facility will code the MDS assessment so that it accurately reflects the resident's status. Section J of the MDS for resident number 23 was modified to reflect that the resident has a prognosis of less than six months to live, and a correction sheet submitted before 12/14/18. MDS staff will be educated by the regional MDS consultant regarding coding the MDS according to RAI guidelines before 12/14/18 Facility MDS staff will review section J for all resident's most recent quarterly assessment before 12/14/18 and complete a modification assessment for any resident with an MDS that requires a correction. Corrections will be submitted as indicated on or before 12/14/18. MDS consultant will conduct an audit of section J for 25% of MDS's completed weekly for four weeks. A QI tool will be utilized. Results of QI audits will be submitted to the QAPI committee monthly for review to monitor for continued compliance.	12/14/18

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

Electronically Signed | 12/10/2018

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F 641	Continued From page 1 statement and it was placed on the resident's chart then she checked the prognosis section on the MDS that indicated six months or less. A review of the medical record with MDS Nurse #1 revealed the prognosis statement was in the chart under the consult tab but not under the Hospice tab. MDS Nurse #1 reported that since the paperwork was in the wrong part of the chart she missed it and therefore had not coded it correctly on the MDS. A review of the Hospice referral form in the medical record revealed a statement by the primary physician that Resident #23 was considered terminally ill and had a life expectancy of six months or less. The referral form was signed by Resident #23's primary facility physician on 9/13/18. On 11/16/18 at 4:29 PM an interview with Director of Nursing revealed it was her expectation that the prognosis section of the MDS be correctly coded when a resident was on Hospice services.	F 641		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident	F 655		12/14/18

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F 655	Continued From page 2 including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to include documented evidence that a written summary of the baseline care plan was provided to residents or resident representatives for 4 of 9 baseline care plans reviewed (Residents #104, 23, 65 and 86).	F 655	The facility will ensure that each resident or their representative receives a summary of the base line care plan and evidence of their receipt of the summary of the baseline care plan is documented in the resident's medical record. Residents #104, 23, 65 and 86 will be	

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F 655	Continued From page 3 Findings included: 1. Resident #104 was admitted to the facility on 10/16/18 with diagnoses that included, in part, cerebrovascular accident, diabetes and hypertension. A review of the admission comprehensive Minimum Data Set (MDS) assessment dated 10/23/18 revealed Resident #104 was cognitively intact. A review of the medical record revealed a baseline care plan was completed 10/17/18. A review of the medical record revealed no documented evidence that a written summary of the baseline care plan was given to the resident or resident representative. On 11/13/18 at 3:38 PM an interview was completed with Resident #104. She stated the facility had not given her a written summary of her baseline care plan. On 11/16/18 at 10:50 AM an interview was completed with MDS Nurse #1. She stated when there was a new admission she completed the baseline care plan, printed the physician orders and gave copies of both to the facility social worker who gave a copy of the baseline care plan and orders to the resident and/or resident representative. On 11/16/18 at 11:23 AM an interview was completed with the Social Work Director. She said she typically received the baseline care plan and physician orders from MDS Nurse #1. She stated when the facility met with the resident	F 655	provided a summary of their baseline care plan before 12/14/18. Facility social worker will audit medical records for residents admitted in the last 30 days. Any resident who does not have documented evidence in the medical record that a baseline care plan was received will receive a summary of their baseline careplan and evident of the receipt will be documented in the resident medical record before 12/14/18. A QI audit tool will be utilized. Facility social worker will be educated by the facility administrator before 12/14/18, regarding the requirement that the facility have evidence documented in the medical record that the baseline care plan was received by the resident or their representative. Medical records director will audit new admissions weekly for four weeks to ensure the receipt of the baseline care plan has been documented in the facility medical record. A QI tool will be utilized. Results of QI audits will be submitted to the QAPI team monthly for review.	

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F 655	Continued From page 4	F 655		

and/or resident representative in the 72 hour meeting she provided copies of the baseline care plan and physician orders to them. She further stated she had not documented or kept any evidence that a copy of the baseline care plan was provided to the resident and/or resident representative and said she was unaware she was supposed to have documented this information.

On 11/16/18 at 4:29 PM an interview was completed with the Director of Nursing (DON). She said when there was a new admission to the facility, a meeting was held with the resident and/or resident representative 72 hours after admission to review the baseline care plan. She stated that typically the DON, Administrator and/or Social Work Director attended the meeting. During the meeting the baseline care plan was reviewed and a copy provided to the resident and/or resident representative. The DON's expectation was that there would be documented evidence that a written summary of the baseline care plan was provided to the resident and/or resident representative.

2. Resident #23 was admitted to the facility on 5/25/18 with diagnoses that included, in part, osteomyelitis and diabetes.

A review of the comprehensive Minimum Data Set (MDS) assessment dated 9/27/18 revealed Resident #23 was cognitively intact.

A review of the medical record revealed a baseline care plan was completed 5/28/18.

A review of the medical record revealed no documented evidence that a written summary of

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the baseline care plan was given to the resident or resident representative.

On 11/16/18 at 10:50 AM an interview was completed with MDS Nurse #1. She stated when there was a new admission she completed the baseline care plan, printed the physician orders and gave copies of both to the facility social worker who gave a copy of the baseline care plan and orders to the resident and/or resident representative.

On 11/16/18 at 11:23 AM an interview was completed with the Social Work Director. She said she typically received the baseline care plan and physician orders from MDS Nurse #1. She stated when the facility met with the resident and/or resident representative in the 72 hour meeting she provided copies of the baseline care plan and physician orders to them. She further stated she had not documented or kept any evidence that a copy of the baseline care plan was provided to the resident and/or resident representative and said she was unaware she was supposed to have documented this information.

On 11/16/18 at 3:47 PM an interview was completed with Resident #23. She stated she did not remember if she received a written summary of her baseline care plan and said when she first came to the facility, "I was out of it."

On 11/16/18 at 4:29 PM an interview was completed with the Director of Nursing (DON). She said when there was a new admission to the facility, a meeting was held with the resident and/or resident representative 72 hours after admission to review the baseline care plan. She

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stated that typically the DON, Administrator and/or Social Work Director attended the meeting. During the meeting the baseline care plan was reviewed and a copy provided to the resident and/or resident representative. The DON's expectation was that there would be documented evidence that a written summary of the baseline care plan was provided to the resident and/or resident representative.

3. Resident #65 was admitted to the facility on 8/3/18 with diagnoses that included, in part, hypertension and gastro-esophageal reflux disease.

A review of the comprehensive Minimum Data Set (MDS) assessment dated 8/10/18 revealed Resident #65 was cognitively intact.

A review of the medical record revealed a baseline care plan was completed 8/4/18.

A review of the medical record revealed no documented evidence that a written summary of the baseline care plan was given to the resident or resident representative.

On 11/16/18 at 10:50 AM an interview was completed with MDS Nurse #1. She stated when there was a new admission she completed the baseline care plan, printed the physician orders and gave copies of both to the facility social worker who gave a copy of the baseline care plan and orders to the resident and/or resident representative.

On 11/16/18 at 11:23 AM an interview was completed with the Social Work Director. She said she typically received the baseline care plan

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and physician orders from MDS Nurse #1. She stated when the facility met with the resident and/or resident representative in the 72 hour meeting she provided copies of the baseline care plan and physician orders to them. She further stated she had not documented or kept any evidence that a copy of the baseline care plan was provided to the resident and/or resident representative and said she was unaware she was supposed to have documented this information.

On 11/16/18 at 4:29 PM an interview was completed with the Director of Nursing (DON). She said when there was a new admission to the facility, a meeting was held with the resident and/or resident representative 72 hours after admission to review the baseline care plan. She stated that typically the DON, Administrator and/or Social Work Director attended the meeting. During the meeting the baseline care plan was reviewed and a copy provided to the resident and/or resident representative. The DON's expectation was that there would be documented evidence that a written summary of the baseline care plan was provided to the resident and/or resident representative.

4. Resident #86 was admitted to the facility on 8/24/18 with diagnoses that included, in part, dementia and seizure disorder.

A review of the comprehensive Minimum Data Set (MDS) assessment dated 8/31/18 revealed Resident #86 had moderately impaired cognition.

A review of the medical record revealed a baseline care plan was completed 8/25/18.

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A review of the medical record revealed no documented evidence that a written summary of the baseline care plan was given to the resident or resident representative.

On 11/16/18 at 10:50 AM an interview was completed with MDS Nurse #1. She stated when there was a new admission she completed the baseline care plan, printed the physician orders and gave copies of both to the facility social worker who gave a copy of the baseline care plan and orders to the resident and/or resident representative.

On 11/16/18 at 11:23 AM an interview was completed with the Social Work Director. She said she typically received the baseline care plan and physician orders from MDS Nurse #1. She stated when the facility met with the resident and/or resident representative in the 72 hour meeting she provided copies of the baseline care plan and physician orders to them. She further stated she had not documented or kept any evidence that a copy of the baseline care plan was provided to the resident and/or resident representative and said she was unaware she was supposed to have documented this information.

On 11/16/18 at 4:29 PM an interview was completed with the Director of Nursing (DON). She said when there was a new admission to the facility, a meeting was held with the resident and/or resident representative 72 hours after admission to review the baseline care plan. She stated that typically the DON, Administrator and/or Social Work Director attended the meeting. During the meeting the baseline care plan was reviewed and a copy provided to the

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F 655	Continued From page 9 resident and/or resident representative. The DON's expectation was that there would be documented evidence that a written summary of the baseline care plan was provided to the resident and/or resident representative.	F 655		
F 867 SS=D	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 staff interviews and record reviews the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions the committee put in place following the 12/8/17 recertification and complaint survey. The facility again received a recited deficiency in the area of accuracy of assessments during the recertification and complaint survey on 11/16/18. The continued failure of the facility during two surveys of record in the same area of deficiency showed a pattern of the facility's inability to maintain an effective QAA program. The tag was cross referenced to: F641: Based on staff interviews and record review the facility failed to accurately code a prognosis of less than six months (section J) on the comprehensive Minimum Data Set (MDS) assessment for 1 of 1 resident (Resident #23) reviewed for Hospice services.	F 867	The facility will maintain an effective QAA program Section J of the MDS for resident number 23 was modified to reflect that the resident has a prognosis of less than six months to live, and a correction sheet submitted before 12/14/18. MDS staff will be educated by the regional MDS consultant regarding coding the MDS according to RAI guidelines before 12/14/18 Facility MDS staff will review section J for all resident's most recent quarterly assessment before 12/14/18 and complete a modification assessment for any resident with an MDS that requires a correction. Corrections will be submitted as indicated on or before 12/14/18.	12/14/18

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F 867	Continued From page 10 During an interview on 11/16/18 at 6:38 p.m., the Administrator revealed the facility's Quality Assurance meetings were held quarterly and as often as need with the committee members, including: the Administrator, the Director of Nursing, the Medical Director, the Social Worker, the Infection Control Nurse, the Activity Director and the Maintenance Director. The Committee would meet and review all identified areas of concern. The Administrator indicated her expectation was for employees to report any concerns immediately to her or the Director of Nursing.	F 867	MDS consultant will conduct an audit of section J for 25% of MDS's completed weekly for four weeks. A QI tool will be utilized. Results of QI audits will be submitted to the QAPI committee monthly for review to monitor for continued compliance.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		12/14/18

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conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

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F 880	Continued From page 12 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to clean a glucometer blood glucose meter used for blood sugar monitoring after performing a finger stick blood sugar and according to the manufacturers recommendations for 1 of 1 (Resident #90) residents. Findings included: A review of the facility policy for "Blood Sampling - Capillary (Finger Sticks)" dated September 2014 indicated (in part) the blood glucose meters intended for reuse are cleaned and disinfected between resident uses with EPA registered disinfectant per directions on package if it is a shared glucometer, and, following the manufacturer's instructions, clean and disinfect reusable equipment, parts (if glucometer is shared), and/or devices after each use and store in /on a clean surface. The policy did not indicate cleaning procedures to follow for individual use of glucometers. A review of the manufacturer's package instructions indicated the glucometer should be cleaned and disinfected using 1 towelette for cleaning and disinfecting and allowing the exteriors to remain wet for the corresponding contact time (2 minutes). Resident number #90 was admitted to the facility	F 880	The facility will maintain an effective infection control program. The facility will revise the policy for cleaning of glucometers to include the cleaning of glucometers intended for individual use before 12/14/18. Glucometers intended for individual use will be stored individually, labeled with the resident's name, and cleaned after use with an approved disinfectant if there is visible blood on the machine. The director of nursing or other RN designee will educate nursing staff on the revised facility policy before 12/14/18. The staff development coordinator or other RN designee will perform competency checks on the cleaning of glucometers three timely weekly for four weeks. A QI audit tool will be utilized. The QI audits will be submitted to the QAPI committee monthly for review.	

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 11/16/2018

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 880	Continued From page 13 on 10/15/18 with a diagnosis of diabetes mellitus. On 11/14/18 at 3:50 PM an observation of Medication Aide #1 completing a finger stick blood sugar test on Resident #90 and putting the glucometer back into the medication cart in a plastic bag without cleaning and disinfecting it. On 11/14/18 at 4:40 PM an interview with Medication Aide #1 revealed she just forgot to clean the glucometer this time. She stated she usually cleans it after each use but was sorry she didn't. On 11/14/18 at 4:50 PM an interview with the Director of Nursing revealed her expectation was that the glucometer is cleaned after each use.	F 880		