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 08/23/2023

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CAMDEN HEALTH AND REHABILITATION	1 MARITHE COURT GREENSBORO, NC 27407

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F 000	INITIAL COMMENTS A complaint survey was conducted from 8/22/23 through 8/23/23. The following intakes were investigated NC00206270, NC00206138, NC00205760, NC00200293, and NC00201121. Event ID# 1RUL11. 4 of 12 allegations resulted in a deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F 580		

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

Electronically Signed | 09/11/2023

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F 580	Continued From page 1 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner (NP), and Regional Nurse Consultant interviews, the facility failed to notify the medical provider and resident representative after a resident, who did not have a diagnosis of diabetes or an order to receive insulin, was mistakenly administered 50/50 insulin (combination of intermediate and fast acting insulin) for 1 of 1 resident reviewed for notification (Resident #1). Findings included: Resident #1 was admitted to the facility on 3/21/23. Review of Resident #1's admission physician orders dated 3/21/23 indicated no orders for the	F 580	Past noncompliance: no plan of correction required.	

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F 580	Continued From page 2	F 580		

resident to receive insulin.

A review of Progress Notes by Nurse #1 for Resident #1 dated 3/23/23 at 6:20 PM (Recorded as Late Entry on 03/24/2023 12:24 AM) revealed Nurse #1 gave 4 units of 50/50 insulin to Resident #1. "Patient has remained stable with no adverse effects noted". There was no documentation in Nurse #1's progress of notification to inform the medical provider or resident representative of the medication error.

A review of the facility reported medication error investigation report conducted and provided by the Corporate Nurse Consultant dated 3/25/23 at 10:30 AM revealed that on 3/22/23 Resident #1 received an injection of 4 units of 50/50 Insulin, in error, during medication administration by Nurse #1 (the Director of Nursing). The investigation further revealed Nurse #1 failed to report the medication error immediately and failed to notify the medical provider and the resident representative.

Attempts made to contact Nurse #1 by phone were not successful.

A telephone interview was completed on 8/22/23 at 5:15 PM with the NP who revealed the DON called her on Thursday evening, 3/23/23, and said she had administered 4 units of 50/50 to Resident #1 who was not a diabetic and did not have an order for insulin. The NP reported she had talked to the DON on Wednesday 3/22/23 and the DON never told her she had made a medication error on 3/22/23. The NP explained the DON led her to believe the error occurred the afternoon of 3/23/23. The NP stated she found out on Saturday 3/25/23 the DON had lied about

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the date of the med error. The NP added had she been made aware the medication error had occurred on 3/22/23 she would have ordered the blood sugar checks at that time.

During an interview with the Corporate Nurse Consultant on 8/22/23 at 3:11 PM she revealed Nurse #1 admitted that she did not immediately report she administered insulin to Resident #1, nor did she inform the family and medical provider when the error occurred. Nurse #1 did not follow facility procedure for notification of medication errors to the medical provider or responsible person.

The facility provided the following Corrective Action Plan with a completion date of 3/25/23.

1. Responsible Person (RP) and Nurse Practitioner (NP) made aware of Insulin administered to Resident #1 in error by DON on 3/23/2023. DON was educated on 6 Rights of Medication Administration and notification of the RP/NP or MD by Regional Clinical Manager on 3/24/2023.

2. All in house residents progress notes and medication errors for the previous 30 days were reviewed by the Assistant Director of Nursing on 3-24-23 for notification to the RP/NP or MD. No other residents were affected.

3. The Director of Nursing and Assistant Director of nursing were educated by the Regional Clinical Manager on 3-24 -2023 on Notifications to RP of any/all changes with Resident, to include medication errors. The Assistant Director of Nursing/Designee will educate licensed Nurses regarding Notifications to RP of any/all changes

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F 580	Continued From page 4 with Resident. This will be completed on 3/24/2023. No Nurse will be allowed to work if In-service not completed by 3/24/2023. This will be implemented into a new hire orientation by the Assistant Director of Nursing on 3/24/2023. 4. The DON/Designee will review all progress notes and medication errors for notification to the RP/NP or MD daily at Clinical Meeting 5x/week, beginning 3/27/2023. ADON/Designee will review all progress notes and medication errors on weekends starting 3/25/2023. x 4 weeks, then weekly x 4 weeks then monthly x 1 month. 5. The Administrator/Designee will bring these audits to the Quality Assurance Committee monthly x 3 consecutive months. The Quality Assurance Committee will review these results and make the determination of further auditing needs. 6. Allegation of Compliance: 3/25/2023. The Corrective Action plan was validated on 8/22/23 and concluded the facility had implemented an acceptable corrective action plan on 3/25/23. Interviews with nursing staff, including agency staff, revealed the facility had provided education and training on medication administration and notification. Staff interviewed all verbalized they received reeducation on medication administration and notification prior to starting their next shift. Review of the monitoring tools of notification were completed weekly as outlined in the corrective action plan with no concerns identified.	F 580		
F 760 SS=D	Residents are Free of Significant Med Errors	F 760		

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F 760	Continued From page 5 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 review and staff, Nurse Practitioner (NP), and Regional Nurse Consultant interviews, the facility failed to prevent a significant medication error when a nurse administered 50/50 insulin (combination of intermediate and fast acting insulin) subcutaneously (into the fat layer under the skin through an injection) to a resident who had no diagnosis of diabetes and no physician's order for the administration of insulin for 1 of 1 resident reviewed for medication errors (Resident #1). Findings included: Resident #1 was admitted to the facility on 3/21/23 with diagnoses that did not include diabetes mellitus. Review of Resident #1's care plan dated 3/21/23 revealed no care area for diabetes. Review of Resident #1's admission physician orders dated 3/21/23 indicated no orders for the resident to receive insulin. Review of the admission Minimum Data Set (MDS) dated 3/25/23 revealed Resident #1 was severely cognitively impaired, and Resident #1 did not receive insulin injections. A review of Progress Notes for Resident #1 dated 3/23/23 at 6:20 PM (Recorded as Late Entry by	F 760	Past noncompliance: no plan of correction required.	

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Nurse #1 on 03/24/2023 at 12:24 AM) revealed Nurse #1 gave 4 units of 50/50 insulin to Resident #1. "Patient has remained stable with no adverse effects noted".

A review of the facility reported medication error investigation conducted by the Corporate Nurse Consultant dated 3/25/23 at 10:30 AM revealed on 3/22/23 Resident #1 received an injection of 4 units of 50/50 Insulin, in error, during medication administration by Nurse #1 (Director of Nursing). Nurse #1 did not provide an explanation as to why the error occurred except to say it was hectic on the unit.
Review of Resident #1's blood sugar checks revealed the following blood sugar readings and information:

03/22/2023 04:21 PM Blood Sugar: 115 mg/dL documented by the Nurse #1
03/22/2023 06:24 PM Blood Sugar: 100 mg/dL documented by the Nurse #1
03/22/2023 10:25 PM Blood Sugar: 102 mg/dl documented by the Nurse #1
03/23/2023 06:34 AM Blood Sugar: 110 mg/dL documented by the Nurse #1
03/23/2023 10:35 AM Blood Sugar: 115 mg/dL documented by the Nurse #1
03/23/2023 02:35 PM Blood Sugar: 111 mg/dL documented by the Nurse #1
03/23/2023 04:23 PM Blood Sugar: 110 mg/dL documented by the Nurse #1

A telephone interview was completed on 8/22/23 at 5:15 PM with the NP who revealed the DON called her on Thursday evening, 3/23/23, and said she had administered 4 units of 50/50 to Resident #1 who was not a diabetic and did not have an order for insulin. The NP further revealed

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that 4 units of 50/50 was a very small dose and probably would not cause harm to the resident. The NP said she researched the peak time of the insulin so that she could order the times for CBGs (capillary blood sugar also known as finger stick blood sugar) and monitoring to be done. The NP reported she had talked to the DON on Wednesday 3/22/23 and the DON never told her that she had made a medication error on 3/22/23, the DON led her to believe the error occurred the afternoon of 3/23/23. The NP stated she found out on Saturday, 3/25/23, the DON had lied about the date of the med error. The NP stated the times she called the DON to check the CBGs, the DON never clarified the med error had occurred on 3/22/23. The NP added, had she been made aware the medication error had occurred on 3/22/23, she would have ordered the blood sugar checks at that time.

During an interview with the Corporate Nurse Consultant on 8/22/23 at 3:11 PM she revealed during her extended investigation into the medication error she was made aware Nurse #1 administered insulin to Resident #1 in error on 3/22/23 not on 3/23/23 as originally reported by Nurse #1. Nurse #1 did not practice the 5 rights of medication administration prior to the administration of insulin to Resident #1.

1. Facility failed to prevent a significant medication error for Resident #1 by administering Insulin injection not prescribed for Resident. Four units of 50/50 Insulin were administered to wrong Resident on 3/22/2023. Resident was monitored by the nurse for Blood sugars over the next 6 hours. On 3-23-23, the NP and RP were notified of the medication error. Resident did not show adverse reaction to the medication error. On

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3-24-23, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were educated by the Regional Clinical Manager on Medication Administration and Notification of changes to RP and NP/MD.

2. The administering Nurse failed to follow the Seven Rights to Medication Administration. Resident received Insulin not prescribed for Resident. DON was educated by Regional Clinical Nurse on 3/24/2023. All Residents receiving medications have the potential to be affected by this deficient practice.

3. The Regional Clinical Manager and ADON educated all Licensed Nurses and Medication Aides to include Seven Rights of Medication Administration and was completed on 3/24/23. No Nurse or Medication Aide will be allowed to work if Inservice if not completed by 3/24/23. The Education will be conducted on Orientation and annually thereafter by SDC/Designee.

4. Med Pass Observations will be conducted by ADON/Designee to ensure medication administration rights are followed. The DON or designee will conduct 5 medication pass observations weekly x 4 weeks, then 3 medication pass observations x 4 weeks, then 1 medication pass observation x 1 month.

5. All Findings will be reported to QAPI monthly ongoing by the DON or designee x 3 consecutive Quality Assurance Meetings. The Quality Assurance Committee will determine if further auditing or education is needed.

6. Allegation of Compliance: 3/25/23.

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F 760	Continued From page 9 The Corrective Action plan was validated on 8/22/23 and concluded the facility had implemented an acceptable corrective action plan on 3/25/23. Interviews with nursing staff, including agency staff and medication aides, revealed the facility had provided education and training on medication administration and notification. Staff interviewed all verbalized they received reeducation on medication administration and notification prior to starting their next shift. Review of the monitoring tools of medication administration were completed weekly as outlined in the corrective action plan with no concerns identified.	F 760		