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 05/08/2018

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 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- (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).	F 580		6/5/18

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

Electronically Signed | 05/31/2018

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 05/08/2018

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 580	Continued From page 1 §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 staff, Nurse Practitioner (NP) and Medical Director interviews and medical record review, the facility failed to notify the on call provider after business hours (5:00 PM) of a change in condition for 1 of 1 resident (Resident #1) reviewed for hospitalizations and failed to notify a family member of an injury of unknown origin (bruising to left eye) for 1 of 2 residents (Resident #3) reviewed for abuse. Findings included: 1. Resident #1 was admitted to the facility on 3/7/18 with diagnoses that included, in part, end stage renal disease, dependence on renal dialysis and dementia. Resident #1 discharged to the hospital on 4/28/18. A review of the hospital emergency department provider note dated 4/28/18 revealed Resident #1 was diagnosed with cellulitis of the left upper extremity. A review of the admission Minimum Data Set (MDS) assessment dated 3/14/18 revealed Resident #1 required limited to extensive assistance with activities of daily living (ADLs).	F 580	The facility was cited for failure to 1) notify the on call provider for a resident after hours regarding a change in the resident status and 2) to notify the resident□s responsible party for one resident with bruising to her eye. Facility policy requires staff to notify the physician of change in resident status. The facility staff notified the facility nurse practitioner at the time the change was noted for resident #1, but failed to contact the on call provider when the nurse practitioner failed to conduct further evaluation regarding the notification. The nurse stated she did not contact the on call provider because she didn□t have knowledge of the nurse practitioner not completing an evaluation of the resident after she was notified of the change for the resident. Facility policy requires staff to notify the resident□s responsible party of any change in the resident□s physical, mental, or psychosocial status.	

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 05/08/2018

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 580	Continued From page 2 A review of the care plan updated 4/24/18 revealed Resident #1 received dialysis and was at risk for edema. Care plan interventions included, "Inform physician of any changes and report and document any complications associated with adverse reaction of dialysis treatment such as edema." A review of a physician order dated 3/8/18 revealed Resident #1 received hemodialysis Monday, Wednesday and Friday. A review of a written statement from Nurse #3 revealed, "On Thursday evening, 4/26/18, I noticed that Resident #1's upper and lower extremities had severe edema. On Friday, 4/27/18, Resident #1 arrived back from dialysis treatment, bilateral arms were red with rash. First shift nurse reported to NP and notified me that she was going to look at area. Resident's Family Member #1 then stated to me that she brought this to the attention of dialysis center and they stated that someone would observe her. No orders or communication was sent back with resident. After an hour of waiting on NP I went to office and she was gone. I put a note in physician (MD) communication book." A review of the MD communication book revealed no note was written to the provider regarding the condition of Resident #1's arms. A review of a late entry nurse's note (1st shift nurse) dated 4/27/18 at 5:30 PM revealed, "Resident leave of absence for dialysis at approximately 10:00 AM. Prior to resident returning from dialysis, Family Member #1 arrived at facility and stated that she was told by dialysis nurse that a MD there was going to assess	F 580	The facility failed to contact the resident□s responsible party regarding the identification of a bruise to the left eye for resident #3, because they attributed the bruise to be related to an earlier fall the resident sustained. The on call provider for resident #1 was contacted on 4/28/18 regarding the change in resident condition and the resident was sent to the emergency room for further evaluation. The responsible party for resident #3 was in the facility on 4/29/18 and notified of the bruise to resident□s eye at that time. DON or RN designee educated licensed nurses regarding the requirements for physician and responsible party notification on or before June 5th 2018. Facility quality committee will review facility 24 hour report, nursing notes, and incident reports five times weekly to identify resident changes of condition and verify that any resident changes in condition have been reported to the attending provider or responsible party in accordance with facility policy and federal regulations by 6/5/18. A QI tool will be utilized. QI tools regarding resident change of condition will be submitted to the quality 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 05/08/2018

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 580	Continued From page 3	F 580		

redness/warmth in left hand and order antibiotics or some kind of medicine for her hand. When resident arrived back at facility, there was no paperwork/documentation of any new instructions or orders ...NP also notified verbally that resident had returned to facility and family requested for NP/MD to see resident today." An addendum to the note was written 5/1/18 and revealed, "NP unsure if she would be able to see resident same day due to the late hour. Passed information on to oncoming nurse that if NP does not see resident in facility this evening (4/27/18) to call after hours on call provider for further instructions."

A review of a nurse's note dated 4/28/18 revealed, "At approximately 8:00 AM Family Member #2 arrived on the unit at the nurse's station and spoke with this nurse stating, 'I was told by two different nurses yesterday that Resident #1 was going to be seen by the doctor. I want her to go to the hospital and I want her to go now!' This nurse asked Family Member #2 what was going on that resident needed to go to the hospital. Family Member #2 stated, 'She is running a fever and her arm is swollen, no one has even looked at her arm.' This nurse in to room to look at resident's arm. This nurse noted the resident's left arm to be slightly larger than the right, red and hot to touch. Resident denies pain at site ...The on call MD notified. New order received: 'Send to emergency room (ER) for evaluation due to left arm being swollen, hot to touch and red.' Resident sent to ER."

A review of the interdisciplinary discharge summary revealed Resident #1's temperature at time of discharge was 98.2 degrees.

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 05/08/2018

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 580	Continued From page 4	F 580		

An interview was completed with Nurse #3 on 5/7/18 at 5:57 PM. She reported that, at baseline, Resident #1 had severe edema to all of her extremities. She reported on Thursday, 4/26/18 she observed Resident #1's left hand was redder than normal and swollen but not weeping so she noted her observations in the MD communication book. She stated Resident #1 had dialysis the next day (4/27/18) and when she arrived back at the facility after dialysis the arm was red, hot to the touch and weeping. Nurse #3 said the resident stated her arm became that way while she was at dialysis. Family Member #1 was with the resident when she returned to the facility and told Nurse #3 that she had asked the dialysis nurse to have the MD assess Resident #1's arm at the dialysis center. Family Member #1 further stated to Nurse #3 that she didn't think the MD looked at the resident's arm while she was at dialysis. Nurse #3 said Nurse #4 (1st shift nurse on 4/27/18) informed the facility NP of the condition of the arm and asked the NP to examine Resident #1. Nurse #3 stated by 6:00 PM the NP had not seen Resident #1 and had left the facility for the evening so she informed the supervisor of Resident #1's condition.

An interview was completed with Nurse #5 on 5/8/18 at 8:33 AM. He said he was the nurse on duty the day Resident #1 was sent to the hospital. He stated Resident #1 typically had edema in her arms. He reported during the morning Family Member #2 came to the facility and informed him that someone needed to examine Resident #1's arm. Nurse #5 stated he assessed the resident's arm and observed that the bottom portion of her left arm near the elbow was warm and red to the touch. He further stated the top of Resident #1's hand was not red and the top of her forearm was

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 05/08/2018

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 580	Continued From page 5	F 580		

not red. Nurse #5 said Family Member #2 stated the MD at the dialysis center was supposed to have examined her arm the day before but didn't. He then demanded the resident be sent to the hospital. Nurse #5 stated he immediately called the on call provider and obtained an order and sent Resident #1 to the hospital.

An interview was completed with Nurse #4 on 5/8/18 at 8:49 AM. She stated Resident #1 was admitted with edema to her hands and arms. She assessed the resident's arm on 4/27/18 before she left for dialysis. Nurse #4's assessment revealed the left arm was edematous, which was her baseline, however, the top of the forearm extending to the top of the hand was more reddened and warm to the touch. Resident #1's temperature was normal when she left for dialysis that morning. She said when the resident returned to the facility from dialysis on 4/27/18 Family Member #1 came in with her and stated the MD at the dialysis center was supposed to have assessed the resident's arm. Nurse #4 reported she reviewed the paperwork from the dialysis center but there was no information that a MD from the center had seen Resident #1. Nurse #4 said she called the dialysis center and requested information be faxed to the facility if resident was seen by the MD. Nurse #4 worked first shift on 4/27/18 and said she stopped on her way out of the building and asked the facility NP to examine Resident #1's arm. She further said the NP informed her if was "after hours" and the NP neither consented or declined to assess the resident. Nurse #4 stated she then told Nurse #3 to check for a fax from the dialysis center and if the NP didn't assess Resident #1 then the on call provider needed to be called.

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 05/08/2018

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 580	Continued From page 6	F 580		

An interview was completed with the facility Nurse Practitioner (NP) on 5/8/18 at 9:25 AM. She stated Resident #1 had end stage renal disease, was on dialysis and had edema on both of her hands. She said when Resident #1 returned from dialysis on 4/27/18 it was after 5:00 PM. The NP recalled that Nurse #4 spoke with her at the facility and asked her to assess Resident #1 and the NP said she informed Nurse #4 that it was after hours. The NP stated the on call process was that any acute issues that needed to be addressed after 5:00 PM during a weekday were called in to the on call provider. The NP said that since it was after 5:00 PM she did not see Resident #1 and that best practice would have been for the nurse to call the on call provider due to the change in the condition of Resident #1's arm.

A follow up interview was completed with Nurse #5 on 5/8/18 at 9:50 AM. He said the on call process worked as follows: the facility NP was at the facility Monday-Friday and available for consult until 5:00 PM. He stated after 5:00 PM the staff were supposed to call the on call provider for any acute issues.

A follow up interview was completed with Nurse #4 on 5/8/18 at 10:20 AM. She said the on call provider was available after 5:00 PM. She said if a staff member called the provider's number after 5:00 PM there was an automated prompt that connected them with the on call provider. Nurse #4 stated since there was a change in the condition of Resident #1's arm and it was a Friday, it would have been best practice for staff to have called the on call provider.

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 05/08/2018

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 580	Continued From page 7	F 580		

An interview was completed with the Clinical Manager at the dialysis center on 5/8/18 at 12:47 PM. She reported when Resident #1 went to dialysis on 4/27/18 she had plus three edema to her bilateral upper extremities, redness to the left upper extremity and weeping edema in her left arm. When the Clinical Manager saw Resident #1 on 4/27/18 during dialysis the resident was not in distress. She said the MD at the dialysis center had not seen Resident #1 on 4/27/18. She further stated a nurse at the dialysis center had noted that Family Member #1 was concerned with Resident #1's left upper extremity and the nurse called the facility and was told someone at the facility would assess Resident #1's arm when she returned to the facility. The Clinical Manager said there was nothing in their assessment at the dialysis center that gave them any indication that the resident needed to be sent to the emergency room that day.

A follow up interview was completed with Nurse #3 on 5/8/18 at 1:10 PM. She stated the process for notifying the on call provider was that if there was a major change in the condition of a resident the on call provider was called. She said the acute change in Resident #1's arm was considered a change in condition. She stated, "It would have been a good idea to call the on call provider but I was thinking the NP was going to follow up with it because she was aware of the situation." She then stated she was unsure if she talked with the supervisor that day about Resident #1's arm.

On 5/8/18 at 2:41 PM an interview was completed with the Medical Director. She stated on call hours during the week were from 5:00 PM-8:00 AM and she expected staff to contact the on call

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 05/08/2018

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 580	Continued From page 8	F 580		

provider after 5:00 PM. She said if the NP told staff it was after hours then the staff member should have called the on call provider. She further stated since the condition of Resident #1's arm had changed to increased redness and was warm to touch she expected that staff would have called the on call provider for direction.

On 5/8/18 at 3:23 PM an interview was completed with the Administrator. She stated she felt the nurse did her job when she notified the NP of Resident #1's arm and later said if the NP hadn't seen the resident then the nurse should have followed up with a phone call to the on call provider.

2. Resident #3 was admitted to the facility on 2/15/17 with diagnosis of dementia.

A record review of the quarterly Minimum Data Set (MDS) assessment dated 4/23/18 revealed the resident had moderately impaired cognition, did not exhibit behaviors during the assessment look-back period and required extensive assistance with all of her activities of daily living (ADL).

A review of the care plans updated on 4/24/18 revealed care plans for self-care deficit and combative behavior toward staff during care and at times toward other residents. Approaches included do not argue with resident and approach resident warmly and positively.

A review of an incident report included in the investigation file revealed Nurse #1 had observed the bruising to the residents left eye on 4/27/18 at 7:31 AM after Nurse Aide (NA) #1 reported it to her.

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 05/08/2018

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 580	Continued From page 9 An interview was conducted on 5/8/18 at 1:45 PM with Nurse #1. She revealed NA #1 reported the bruising on Resident #3's left eye to her on the morning of 4/27/18 and she reported it to the Assistant Director of Nursing (ADON) at that time. She further revealed she completed an incident report but did not notify the resident's family member because she was too busy. An interview was conducted on 5/8/18 at approximately 2:15 PM with the ADON. She revealed Nurse #1 had reported the bruise on Resident #3's left eye to her on the morning of 4/27/18 and she instructed her to complete an incident report and call the family. The ADON revealed when there are incidents of unknown origin and an incident report is filled out, the nurse completing the incident report is expected to notify the physician and family member. An interview was conducted on 5/8/18 at 3:30 PM with the Administrator. She revealed the staff were expected to notify the physician and the family member of injuries of unknown origin.	F 580		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and	F 607		6/5/18

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 05/08/2018

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 607	Continued From page 10 §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to follow its abuse policy to submit a 24 hour initial allegation report and a 5 working day investigation report to the State Survey Agency within the required timeframes for 2 of 2 residents (Resident #1 and Resident #3) reviewed for abuse. Findings included: A review of the facility abuse policy dated December 2009, the section titled "Reporting Abuse to State Agencies and Other Entities/Individuals" read, in part: 1. Should a suspected violation or abuse be reported, the facility Administrator, or his/her designee, will promptly notify the following persons or agencies of such incident: a. The State licensing/certification agency responsible for surveying/licensing the facility. 2. The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within 5 working days of the occurrence of the incident. 3. Injuries of unknown origin be promptly reported to: a. The State licensing/certification agency responsible within 24 hours. 1. Resident #1 was admitted to the facility on 3/7/18 with diagnoses that included, in part, dementia. She discharged to the hospital on 4/28/18.	F 607	The facility was cited for failure to follow its abuse policy to submit an initial allegation reports and a five day working report within the required timeframes. Facility policy requires the administrator or designee send a 24 hour initial allegation report and a five day working report to the state agency for allegations of abuse and injuries of unknown origin. The facility failed to submit the initial allegation report for resident #1 within the required timeframes because the report was faxed to an incorrect number. The five day working report was not sent to the state agency for resident #1 due to an oversight by the director of nursing services. The 24 hour initial report was not sent within the required timeframes for resident #3 due to staff not identifying the discolored area to the resident□s eye as an injury that was reportable to the state agency administrator according to the facility abuse policy. According to the facility abuse policy and federal regulations, an injury of unknown source is defined as an injury that meets both of the following conditions: 1) The source of the injury was not observed by any person or the source of the injury could not be explained by the	

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 05/08/2018

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 607	Continued From page 11 A review of the admission comprehensive Minimum Data Set (MDS) assessment dated 3/14/18 revealed Resident #1 was cognitively intact and had no negative behaviors. A review of the quarterly MDS assessment dated 4/12/18 revealed Resident #1 displayed other behavioral symptoms one to three days during the seven day look back period. A review of the facility's abuse investigations revealed on 4/29/18 Resident #1's family member reported an allegation of abuse. A review of the 24 hour initial allegation report dated 4/30/18 revealed the family member alleged a staff member pinched Resident #1 on her arm. A review of the facility facsimile confirmation sheet revealed an error message because the facility faxed the report to the incorrect number. A review of the 5 working day investigation report dated 5/4/18 and completed by the former Director of Nursing (DON) revealed the allegation of abuse was unsubstantiated. Further review of the investigation report revealed it was not sent to the State Survey Agency. A telephone attempt to contact the former DON on 5/7/18 at 5:02 PM was unsuccessful. On 5/8/18 at 9:13 AM an interview was completed with the Administrator. She said policies on abuse are reviewed with staff upon hire, annually and on an as needed basis. She stated the staff member she assigned who conducted the abuse investigation also faxed the results to the State Survey Agency. She said she learned on 5/7/18	F 607	resident; and 2) The injury is suspicious because of: a. The extent of the injury; or b. The location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma; or c. The number of injuries observed at one particular point in time; or d. The incidence of injuries over time. The initial allegation report and five day working report for resident #1 was faxed to the state survey agency on 5/8/18. The initial allegation report for resident #3 was faxed to the state survey agency on 4/29/18 and was present in the investigation folder at the time of survey. The five day working report for resident #3 was faxed to the state survey agency on 5/4/18 and was present in the investigation file at the time of the survey. Facility nursing, therapy, housekeeping, dietary and administrative staff will be inserviced by the staff development nurse or other RN designee regarding abuse reporting to include injuries of unknown source on or before June 5, 2018. Facility administrator will track all initial allegation reports and five day investigation reports to ensure reports are sent timely and to the correct fax number. A QI tool will be utilized. Facility administrator will submit completed QI tools to the facility quality committee for review monthly for 3	

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 05/08/2018

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 607	Continued From page 12	F 607		

that the former DON had abruptly resigned. The Administrator indicated she did not know why the 24 hour initial allegation report was faxed to the wrong number. She further stated she did not think the former DON followed up and sent the 5 working day investigation report to the State Survey Agency. She said she expected abuse investigation reports to be completed and sent to the State Survey Agency within the required timeframes.

2. Resident #3 was admitted to the facility on 2/15/17 with diagnosis of dementia.

A record review of the Quarterly Minimum Data Set (MDS) assessment dated 4/23/18 revealed the resident had moderately impaired cognition, did not exhibit behaviors during the assessment look-back period and required extensive assistance with all of her Activities of Daily Living (ADLs).

A review of the care plans updated on 4/24/18 revealed care plans for self-care deficit and combative behavior toward staff during care and at times toward other residents. Approaches included do not argue with resident and approach resident warmly and positively.

A record review revealed a nurse's note dated 4/28/18 at 2:49 PM indicating the resident was "observed with an ecchymotic area to left orbital at beginning of shift, unable to give cause of bruising. Note left in MD's book."

A review of the investigation report the facility initiated revealed an injury of unknown origin was discovered on 4/29/18. There was no

months.

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 05/08/2018

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 607	Continued From page 13	F 607		

documented evidence of a 24 hour report in the investigation file.

A review of an incident report included in the investigation file revealed Nurse #1 had observed the bruising to the residents left eye on 4/27/18 at 7:31 AM after NA #1 reported it to her.

A review of a nurses note dated 4/29/18 at 6:24 PM revealed Nurse #2 initiated the investigation after the resident's family member brought the bruise to her attention that day and wanted to know what happened. Nurse #2 observed an "ecchymotic bruised area to the left lower orbital space of her left eye. She has some yellowish tinge to the area which is indicative of not being a fresh bruise. She has some bluish color to the lower orbit as well as yellow coloration to the lower lateral side of the eye orbit. She has no pain". Nurse #2 informed the resident's family member that an investigation would be conducted.

An interview was conducted on 5/8/18 at 1:45 PM with Nurse #1. She revealed the NA #1 reported the bruising to her on the morning of 4/27/18 and she reported it to the Assistant Director of Nursing (ADON) at that time. She further revealed she completed an incident report but did not notify the resident's family member because she was too busy.

An interview was conducted on 5/8/18 at approximately 2:15 PM with the ADON. She revealed Nurse #1 had reported the bruise to her on the morning of 4/27/18. She instructed her to complete an incident report and call the family. She further revealed she assumed the area was related to a fall that the resident had on 4/21/18

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 05/08/2018

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 607	Continued From page 14 with no injuries observed and that was why she did not call the Administrator or the Director of Nursing to initiate an investigation. She stated she would not have been the one to complete the 24 hour report, it would have been the DON or Administrator. An interview was conducted on 5/8/18 at 3:30 PM with the Administrator. She revealed it was her understanding that incidents that are not suspected to be abuse do not require a 24 hour report. She further revealed the staff were to notify the physician and the family member of incidents of unknown origin.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		6/5/18

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 05/08/2018

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 609	Continued From page 15 §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 staff interviews and record review, the facility failed to submit a 24 hour initial allegation report and 5 working day investigation report to the State Survey Agency within the required timeframes for 2 of 2 residents (Resident #1 and Resident #3) reviewed for abuse. Findings included: 1. Resident #1 was admitted to the facility on 3/7/18 with diagnoses that included, in part, dementia. She discharged to the hospital on 4/28/18. A review of the admission comprehensive Minimum Data Set (MDS) assessment dated 3/14/18 revealed Resident #1 was cognitively intact and had no negative behaviors. A review of the quarterly MDS assessment dated 4/12/18 revealed Resident #1 displayed other behavioral symptoms one to three days during the seven day look back period. A review of the facility's abuse investigations revealed on 4/29/18 Resident #1's family member reported an allegation of abuse. A review of the 24 hour initial allegation report dated 4/30/18 revealed the family member	F 609	The facility was cited for failure to follow its abuse policy to submit an initial allegation reports and a five day working report within the required timeframes. Facility policy requires the administrator or designee send a 24 hour initial allegation report and a five day working report to the state agency for allegations of abuse and injuries of unknown origin. The facility failed to submit the initial allegation report for resident #1 within the required timeframes because the report was faxed to an incorrect number. The five day working report was not sent to the state agency for resident #1 due to an oversight by the director of nursing services. The 24 hour initial report was not sent within the required timeframes for resident #3 due to staff not identifying the discolored area to the resident□s eye as an injury that was reportable to the state agency administrator according to the facility abuse policy. According to the facility abuse policy and federal regulations, an injury of unknown source is defined as an injury that meets both of	

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 05/08/2018

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 609	Continued From page 16 alleged a staff member pinched Resident #1 on her arm. A review of the facility facsimile confirmation sheet revealed an error message because the facility faxed the report to the incorrect number. A review of the 5 working day investigation report dated 5/4/18 and completed by the former Director of Nursing (DON) revealed the allegation of abuse was unsubstantiated. Further review of the investigation report revealed it was not sent to the State Survey Agency. A telephone attempt to contact the former DON on 5/7/18 at 5:02 PM was unsuccessful. On 5/8/18 at 9:13 AM an interview was completed with the Administrator. She stated the staff member she assigned who conducted the abuse investigation also faxed the results to the State Survey Agency. She said she learned on 5/7/18 that the former DON had abruptly resigned. The Administrator indicated she did not know why the 24 hour initial allegation report was faxed to the wrong number. She further stated she did not think the former DON followed up and sent the 5 working day investigation report to the State Survey Agency. She said she expected abuse investigation reports to be completed and sent to the State Survey Agency within the required timeframes. 2. Resident #3 was admitted to the facility on 2/15/17 with diagnosis of dementia. A record review of the Quarterly Minimum Data Set (MDS) assessment dated 4/23/18 revealed the resident had moderately impaired cognition, did not exhibit behaviors during the assessment	F 609	the following conditions: 1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and 2) The injury is suspicious because of: a. The extent of the injury; or b. The location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma; or c. The number of injuries observed at one particular point in time; or d. The incidence of injuries over time. The initial allegation report and five day working report for resident #1 was faxed to the state survey agency on 5/8/18. The initial allegation report for resident #3 was faxed to the state survey agency on 4/29/18 and was present in the investigation folder at the time of survey. The five day working report for resident #3 was faxed to the state survey agency on 5/4/18 and was present in the investigation file at the time of the survey. Facility nursing, therapy, housekeeping, dietary and administrative staff will be inserviced by the staff development nurse or other RN designee regarding abuse reporting to include injuries of unknown source on or before June 5, 2018. Facility administrator will track all initial allegation reports and five day investigation reports to ensure reports are sent timely and to the correct fax number.	

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 05/08/2018

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 609	Continued From page 17 look-back period and required extensive assistance with all of her Activities of Daily Living (ADLs). A review of the care plans updated on 4/24/18 revealed care plans for self-care deficit and combative behavior toward staff during care and at times toward other residents. Approaches included do not argue with resident and approach resident warmly and positively. A record review revealed a nurse's note dated 4/28/18 at 2:49 PM indicating the resident was "observed with an ecchymotic area to left orbital at beginning of shift, unable to give cause of bruising. Note left in MD's book." A review of the investigation report the facility initiated revealed an injury of unknown origin was discovered on 4/29/18. There was no documented evidence of a 24 hour report in the investigation file. A review of an incident report included in the investigation file revealed Nurse #1 had observed the bruising to the residents left eye on 4/27/18 at 7:31 AM after NA #1 reported it to her. A review of a nurses note dated 4/29/18 at 6:24 PM revealed Nurse #2 initiated the investigation after the resident's family member brought the bruise to her attention that day and wanted to know what happened. Nurse #2 observed an "ecchymotic bruised area to the left lower orbital space of her left eye. She has some yellowish tinge to the area which is indicative of not being a fresh bruise. She has some bluish color to the lower orbit as well as yellow coloration to the lower lateral side of the eye orbit. She has no	F 609	A QI tool will be utilized. Facility administrator will submit completed QI tools to the facility quality committee for review monthly for 3 months.	

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 05/08/2018

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 609	Continued From page 18	F 609		

pain". Nurse #2 informed the resident's family member that an investigation would be conducted.

An interview was conducted on 5/8/18 at 1:45 PM with Nurse #1. She revealed the NA #1 reported the bruising to her on the morning of 4/27/18 and she reported it to the Assistant Director of Nursing (ADON) at that time. She further revealed she completed an incident report but did not notify the resident's family member because she was too busy.

An interview was conducted on 5/8/18 at approximately 2:15 PM with the ADON. She revealed Nurse #1 had reported the bruise to her on the morning of 4/27/18. She instructed her to complete an incident report and call the family. She further revealed she assumed the area was related to a fall that the resident had on 4/21/18 with no injuries observed and that was why she did not call the Administrator or the Director of Nursing to initiate an investigation. She stated she would not have been the one to complete the 24 hour report, it would have been the DON or the Administrator.

An interview was conducted on 5/8/18 at 3:30 PM with the Administrator. She revealed that it was her understanding that incidents that are not suspected to be abuse do not require a 24 hour report.