DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM APPROVED		
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED		
		345547	B. WING		C 11/16/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				1 MARITHE COURT			
CAMDEN	HEALTH AND REHABILI	IATION		GREENSBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
F 641 SS=D	· · · · · · · · · · · · · · · · · · ·	ents	F 64	1	12/14/18		
	resident's status. This REQUIREMENT	of Assessments. It accurately reflect the is not met as evidenced					
	facility failed to accur less than six months comprehensive Minin	num Data Set (MDS) resident (Resident #23)		The facility will code the MDS assessment so that it accurately reflect the resident's status. Section J of the MDS for resident numb 23 was modified to reflect that the	er		
	Findings included:			resident has a prognosis of less than si months to live, and a correction sheet submitted before 12/14/18.	x		
		mitted to the facility on es that included, in part, nd malnutrition.		MDS staff will be educated by the regio MDS consultant regarding coding the MDS according to RAI guidelines befor			
		al record revealed Resident Hospice services on 9/14/18.		12/14/18 Facility MDS staff will review section J f			
	dated 9/27/18 revealed Hospice services. Fu	rehensive MDS assessment ed the resident received irther review of the MDS a prognosis of less than six as not checked.		all resident's most recent quarterly assessment before 12/14/18 and complete a modification assessment fo any resident with an MDS that requires correction. Corrections will be submitted as indicated on or before 12/14/18.	r a		
	significant change in completed on Reside admitted to Hospice s	Nurse #1. She said a status assessment was nt #23 because she was services. She acknowledged		MDS consultant will conduct an audit or section J for 25% of MDS's completed weekly for four weeks. A QI tool will be utilized.	F		
	statement from the pl had six months or les	(section J) was not e had not yet received a hysician that the resident s of life expectancy. She nce the physician signed the		Results of QI audits will be submitted to the QAPI committee monthly for review monitor for continued compliance.			
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE	(X6) DATE		
	cally Signed				12/10/2018		

**Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/20/2018 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345547	B. WING				C 16/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
		TATION		1	MARITHE COURT		
CANIDEN	HEALTH AND REHABILI	IATION		Ģ	GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 641 F 655 SS=E	statement and it was chart then she checke the MDS that indicate review of the medical revealed the prognosi under the consult tab tab. MDS Nurse #1 m paperwork was in the missed it and therefor on the MDS. A review of the Hospie medical record reveal primary physician that considered terminally of six months or less. signed by Resident #2 physician on 9/13/18. On 11/16/18 at 4:29 F of Nursing revealed it the prognosis section coded when a resider Baseline Care Plan CFR(s): 483.21(a)(1)- §483.21 Comprehenss Planning §483.21(a) Baseline ( §483.21(a)(1) The fac implement a baseline that includes the instr effective and person-of that meet professiona The baseline care pla (i) Be developed withi admission.	placed on the resident's ad the prognosis section on d six months or less. A record with MDS Nurse #1 is statement was in the chart but not under the Hospice eported that since the wrong part of the chart she re had not coded it correctly ce referral form in the ed a statement by the t Resident #23 was ill and had a life expectancy The referral form was 23's primary facility 20 M an interview with Director was her expectation that of the MDS be correctly at was on Hospice services. (3) ive Person-Centered Care Care Plans cility must develop and care plan for each resident uctions needed to provide centered care of the resident il standards of quality care. n must- n 48 hours of a resident's um healthcare information		641			12/14/18

Event ID: 40CU11

Facility ID: 061197

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED	
		345547	B. WING				C 16/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CAMDEN	HEALTH AND REHABILI	TATION						
				G	REENSBORO, NC 27407			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE				
F 655	<ul> <li>including, but not limit</li> <li>(A) Initial goals based</li> <li>(B) Physician orders.</li> <li>(C) Dietary orders.</li> <li>(D) Therapy services.</li> <li>(E) Social services.</li> <li>(F) PASARR recommendation</li> <li>§483.21(a)(2) The fact comprehensive care provides and the comprehensive care provides and the comprehension.</li> <li>(ii) Meets the requiremendation (b) of this section (excert this section).</li> <li>§483.21(a)(3) The fact resident and their reprovides and their reprovides and the care provides and the care provides and the care provides and the care provides and administered by the fact on behalf of the facility (iv) Any updated infort of the comprehensive This REQUIREMENT by:</li> <li>Based on resident and reprovident and reprovident and reprovident and reprovident and reprovides and administered by the fact on the comprehensive the baseline care part or resident and reprovident and the care part or resident and reprovident and the care part or resident and the care parts or the part or the part of the part of the care parts or the part of the</li></ul>	ted to- I on admission orders. endation, if applicable. cility may develop a blan in place of the baseline rehensive care plan- in 48 hours of the resident's ments set forth in paragraph cepting paragraph (b)(2)(i) of cility must provide the resentative with a summary lan that includes but is not if the resident. resident's medications and treatments to be acility and personnel acting y. mation based on the details is care plan, as necessary. is not met as evidenced and staff interviews and	F	655	The facility will ensure that each reside or their representative receives a summary of the base line care plan ar evidence of their receipt of the summa of the baseline care plan is documente the resident's medical record. Residents #104. 23. 65 and 86 will be	id ry		

Facility ID: 061197

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		ND HUMAN SERVICES				FOR	D: 12/20/2018 M APPROVEI D. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345547	B. WING				/16/2018	
NAME OF PI	ROVIDER OR SUPPLIER	•	1	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
CAMDEN	HEALTH AND REHABILI	ITATION			MARITHE COURT REENSBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 655	Continued From page	e 3	F 6	355				
	Findings included:				provided a summary of their baseline plan before 12/14/18.	care		
					Facility social worker will audit medica records for residents admitted in the la 30 days. Any resident who does not h documented evidence in the medical record that a baseline care plan was	ast		
		IDS) assessment dated esident #104 was cognitively			received will receive a summary of the baseline careplan and evident of the receipt will be documented in the resid medical record before 12/14/18. A QI audit tool will be utilized.			
		as completed 10/17/18.			Facility social worker will be educated	by		
	documented evidence	cal record revealed no e that a written summary of n was given to the resident ative.			the facility administrator before 12/14/ regarding the requirement that the fac have evidence documented in the mer record that the baseline care plan was received by the resident or their	ility dical		
		lent #104. She stated the			representative.			
	baseline care plan.	her a written summary of her			Medical records director will audit new admissions weekly for four weeks to ensure the receipt of the baseline care			
	completed with MDS there was a new adm	AM an interview was Nurse #1. She stated when hission she completed the rinted the physician orders			plan has been documented in the facil medical record. A QI tool will be utilize Results of QI audits will be submitted	ed.		
	and gave copies of b	oth to the facility social opy of the baseline care plan			the QAPI team monthly for review.			
	completed with the S said she typically rec and physician orders	AM an interview was ocial Work Director. She eived the baseline care plan from MDS Nurse #1. She ty met with the resident						

If continuation sheet Page 4 of 14

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345547	B. WING				C 16/2018	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
	HEALTH AND REHABILI	ΤΑΤΙΟΝ		1	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 655	and/or resident represented in the provided plan and physician or stated she had not do evidence that a copy was provided to the representative and sa was supposed to have information. On 11/16/18 at 4:29 F completed with the Di She said when there is facility, a meeting was and/or resident represe admission to review the stated that typically the and/or Social Work D meeting. During the replan was reviewed and resident and/or	sentative in the 72 hour I copies of the baseline care ders to them. She further boumented or kept any of the baseline care plan esident and/or resident aid she was unaware she e documented this PM an interview was irector of Nursing (DON). was a new admission to the s held with the resident sentative 72 hours after he baseline care plan. She he DON, Administrator irector attended the meeting the baseline care had a copy provided to the ent representative. The as that there would be e that a written summary of n was provided to the ent representative. admitted to the facility on es that included, in part, betes. rehensive Minimum Data nt dated 9/27/18 revealed gnitively intact. cal record revealed a as completed 5/28/18.	F	655				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							D: 12/20/2018 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345547	B. WING				C 16/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CAMDEN	HEALTH AND REHABILI	TATION		1	MARITHE COURT		
e, and En			GREENSBORO, NC 27407		GREENSBORO, NC 27407		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page the baseline care plar or resident representa On 11/16/18 at 10:50 completed with MDS there was a new adm baseline care plan, pr and gave copies of bo worker who gave a co and orders to the resi representative. On 11/16/18 at 11:23 completed with the So said she typically rece and physician orders stated when the facilit and/or resident represe meeting she provided plan and physician or stated she had not do evidence that a copy was provided to the re- representative and sa was supposed to have information. On 11/16/18 at 3:47 F completed with Resid not remember if she r of her baseline care p came to the facility, "I On 11/16/18 at 4:29 F	AM an interview was Nurse #1. She stated when ission she completed the inted the physician orders oth to the facility social opy of the baseline care plan dent and/or resident AM an interview was ocial Work Director. She eived the baseline care plan from MDS Nurse #1. She ty met with the resident sentative in the 72 hour I copies of the baseline care ders to them. She further ocumented or kept any of the baseline care plan esident and/or resident uid she was unaware she e documented this PM an interview was ent #23. She stated she did received a written summary of an and said when she first was out of it."	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
	She said when there facility, a meeting was and/or resident represent	was a new admission to the s held with the resident sentative 72 hours after he baseline care plan. She					

Facility ID: 061197

If continuation sheet Page 6 of 14

		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 12/20/2018 // APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345547	B. WING				C 16/2018
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CAMDEN	HEALTH AND REHABILI	TATION			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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 655	stated that typically th and/or Social Work D meeting. During the r plan was reviewed an resident and/or reside DON's expectation wa documented evidence the baseline care plan resident and/or reside 3. Resident #65 was a 8/3/18 with diagnoses hypertension and gas disease. A review of the compr Set (MDS) assessme Resident #65 was cog A review of the medic baseline care plan wa A review of the medic documented evidence the baseline care plan wa A review of the medic documented evidence the baseline care plan or resident representa On 11/16/18 at 10:50 completed with MDS there was a new adm baseline care plan, pr and gave copies of bo worker who gave a co and orders to the resi representative. On 11/16/18 at 11:23 completed with the So	<ul> <li>a DON, Administrator irrector attended the meeting the baseline care id a copy provided to the ent representative. The as that there would be that a written summary of a was provided to the ent representative.</li> <li>admitted to the facility on a that included, in part, tro-esophageal reflux</li> <li>rehensive Minimum Data nt dated 8/10/18 revealed gnitively intact.</li> <li>al record revealed a as completed 8/4/18.</li> <li>al record revealed no e that a written summary of n was given to the resident ative.</li> <li>AM an interview was Nurse #1. She stated when ission she completed the inted the physician orders oth to the facility social opy of the baseline care plan dent and/or resident</li> </ul>	F	655			

Facility ID: 061197

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DEPART CENTER	FORM	D: 12/20/2018 MAPPROVED D. 0938-0391						
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345547	B. WING				C 16/2018	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
CAMDEN HEALTH AND REHABILITATION				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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 655	and physician orders stated when the facilit and/or resident repres meeting she provided plan and physician or stated she had not do evidence that a copy was provided to the re representative and sa was supposed to have information. On 11/16/18 at 4:29 F completed with the Di She said when there facility, a meeting was and/or resident repres admission to review th stated that typically the and/or Social Work D meeting. During the r plan was reviewed an resident and/or reside DON's expectation was documented evidence the baseline care plan resident and/or reside 4. Resident #86 was a 8/24/18 with diagnose dementia and seizure A review of the comprise Set (MDS) assessme	from MDS Nurse #1. She by met with the resident sentative in the 72 hour copies of the baseline care ders to them. She further boumented or kept any of the baseline care plan esident and/or resident and she was unaware she e documented this PM an interview was rector of Nursing (DON). was a new admission to the sheld with the resident sentative 72 hours after the baseline care plan. She the DON, Administrator irector attended the meeting the baseline care to a copy provided to the ent representative. The as that there would be that a written summary of the was provided to the ent representative. admitted to the facility on es that included, in part, disorder. The then sum Data ant dated 8/31/18 revealed derately impaired cognition. al record revealed a	F	655				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345547	B. WING	NG.			C	
NAME OF PF	ROVIDER OR SUPPLIER	040047			STREET ADDRESS, CITY, STATE, ZIP CODE	11/	16/2018	
					1 MARITHE COURT			
CAMDEN	HEALTH AND REHABILI	IATION			GREENSBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 655	the baseline care plan or resident representation Completed with MDS there was a new adm baseline care plan, pr and gave copies of bo worker who gave a co and orders to the resi representative. On 11/16/18 at 11:23 completed with the So said she typically rece and physician orders stated when the facilit and/or resident representative and physician or stated she had not do evidence that a copy was provided to the re- representative and sa was supposed to have information. On 11/16/18 at 4:29 F completed with the Di She said when there facility, a meeting was and/or resident representative and sa was supposed to have information.	al record revealed no e that a written summary of n was given to the resident ative. AM an interview was Nurse #1. She stated when ission she completed the inted the physician orders oth to the facility social opy of the baseline care plan dent and/or resident AM an interview was ocial Work Director. She eived the baseline care plan from MDS Nurse #1. She ty met with the resident sentative in the 72 hour I copies of the baseline care ders to them. She further ocumented or kept any of the baseline care plan esident and/or resident tid she was unaware she e documented this PM an interview was irector of Nursing (DON). was a new admission to the s held with the resident sentative 72 hours after he baseline care plan. She he DON, Administrator	F	655				
	meeting. During the r							

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	-	ND HUMAN SERVICES	-		PRINTED: 12/20/20 FORM APPROV OMB NO. 0938-03		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C 11/16/2018		
		345547	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
CAMDEN	HEALTH AND REHABILI	ITATION		1 MARITHE COURT GREENSBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIO		
F 655	DON's expectation w	ent representative. The as that there would be e that a written summary of n was provided to the	F 65	5			
F 867 SS=D	§483.75(g)(2) The qu assurance committee (ii) Develop and imple action to correct iden	(ii) ssessment and assurance. ality assessment and	F 86	7	12/14/18		
	facility's Quality Asse Committee (QAA) fail procedures and moni committee put in place recertification and con again received a recit accuracy of assessm recertification and con The continued failure surveys of record in t	te following the 12/8/17 mplaint survey. The facility ted deficiency in the area of ents during the mplaint survey on 11/16/18. To f the facility during two he same area of deficiency he facility's inability to		The facility will maintain an effective program Section J of the MDS for resident nur 23 was modified to reflect that the resident has a prognosis of less than months to live, and a correction shee submitted before 12/14/18. MDS staff will be educated by the reg MDS consultant regarding coding the MDS according to RAI guidelines bef 12/14/18	mber six st gional		
	review the facility faile prognosis of less that the comprehensive M	interviews and record ed to accurately code a n six months (section J) on linimum Data Set (MDS) I resident (Resident #23)		Facility MDS staff will review section all resident's most recent quarterly assessment before 12/14/18 and complete a modification assessment any resident with an MDS that requir correction. Corrections will be submit as indicated on or before 12/14/18.	for es a		

Event ID: 40CU11

Facility ID: 061197

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/20/2018 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION			PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED C
		345547	B. WING			/16/2018
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CAMDEN	HEALTH AND REHABILI	TATION		1 MARITHE COURT GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 867	Continued From page	9 10	F 86	57		
F 880 SS=D	Administrator reveale Assurance meetings often as need with the including: the Adminis Nursing, the Medical the Infection Control I and the Maintenance would meet and revie concern. The Adminis expectation was for e concerns immediately Nursing. Infection Prevention & CFR(s): 483.80(a)(1)() §483.80 Infection Con The facility must esta infection prevention a designed to provide a comfortable environm development and trar diseases and infection §483.80(a) Infection p program. The facility must esta and control program ( a minimum, the follow §483.80(a)(1) A syste reporting, investigatin and communicable di staff, volunteers, visit providing services un	were held quarterly and as e committee members, strator, the Director of Director, the Social Worker, Nurse, the Activity Director Director. The Committee w all identified areas of strator indicated her mployees to report any to her or the Director of & Control (2)(4)(e)(f) htrol blish and maintain an nd control program a safe, sanitary and hent and to help prevent the hismission of communicable ns. prevention and control blish an infection prevention (IPCP) that must include, at ving elements: em for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals	F 88	MDS consultant will conduct an a section J for 25% of MDS's com weekly for four weeks. A QI tool utilized. Results of QI audits will be subm the QAPI committee monthly for monitor for continued compliance	pleted will be nitted to review to	12/14/18

Facility ID: 061197

If continuation sheet Page 11 of 14

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345547	B. WING				16/2018	
NAME OF PF	ROVIDER OR SUPPLIER		•	ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE			
CAMDEN	HEALTH AND REHABILI	TATION			1 MARITHE COURT GREENSBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 880	accepted national sta §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communication infections before they persons in the facility (ii) When and to whore communicable disease reported; (iii) Standard and tran- to be followed to prev (iv)When and how isco- resident; including bu (A) The type and dura- depending upon the in- involved, and (B) A requirement than least restrictive possill circumstances. (v) The circumstances- must prohibit employed disease or infected sk- contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dim §483.80(a)(4) A systemi identified under the fa- corrective actions tak §483.80(e) Linens. Personnel must hand	to §483.70(e) and following ndards; standards, policies, and ogram, which must include, lance designed to identify ble diseases or can spread to other ; m possible incidents of se or infections should be asmission-based precautions ent spread of infections; blation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ble for the resident under the s under which the facility ees with a communicable kin lesions from direct a or their food, if direct he disease; and procedures to be followed rect resident contact. em for recording incidents hcility's IPCP and the en by the facility. le, store, process, and	F	880				
		le, store, process, and to prevent the spread of						

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DEPARTI CENTER	PRINTED: 12/20/2018 FORM APPROVED OMB NO. 0938-0391							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345547 B. WING			C 11/16/2018			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
CAMDEN HEALTH AND REHABILITATION								
0(0)5				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	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE			
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		F 88	The facility will maintain an effective infection control program.				
	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.			The facility will revise the policy for cleaning of glucometers to include the cleaning of glucometers intended for individual use before 12/14/18.				
	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			Glucometers intended for individual us will be stored individually, labeled with 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	the the			
	instructions indicated cleaned and disinfect cleaning and disinfect exteriors to remain we contact time (2 minute	the glucometer should be ed using 1 towelette for ing and allowing the et for the corresponding		QAPI committee monthly for review.				

Facility ID: 061197

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR CENTERS FOR MEDICARE & MEDICAID SERVICES OMB N									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		345547	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 880	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	880					

Facility ID: 061197

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