PRINTED: 02/20/2023 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER CAMDEN HEALTH AND REHABILITATION SUMMARY SYNTHMENT OF GENERATED BY VILL. (SACH LOSS CANDES ON NO. 27407 REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS A complaint investigation and follow up survey was conducted from 1/17/23 through 1/23/23. Event IDE 65M011 and OX.01/21. The following intakes were investigated NC00195636, NC0019640, and NC00196500, NC0019650	, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
CAMDEN HEALTH AND REHABILITATION CREMSBORO, NC 27407 TAG FORDING SUMMARY STATEMENT OF DEFICIENCES (SEASON, NC 27407) FOREINS CREMSBORO, NC 27407 FOREINS CREMSBORO, NC 27407 FORDING SUMMARY STATEMENT OF DEFICIENCES (SEATON SPOULD BE CROSS-RESERVED TO THE APPROPRIATE DEFINITION OF CREATED STATEMENT OF CORRECTION SHOULD BE CROSS-RESERVED TO THE APPROPRIATE DEFINITION OF CREATE STATEMENT OF OF			345547	B. WING		C 01/23/2023
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE					1 MARITHE COURT	,
A complaint investigation and follow up survey was conducted from 1/17/23 through 1/23/23. Event ID# 65M011 and OXQJ12. The following intakes were investigated NC00196305. NC000196305. NC00196305.	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE COMPLETION
was conducted from 1/17/23 through 1/23/23 Event ID# 65M011 and OXQJ12. The following intakes were investigated NCO0195636, NCO0196305, NCO0196440, and NCO0196900. 2 of the 7 complaint allegations were substantiated resulting in deficiencies. F 610 SS=D CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigation 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 record review and staff interview, the facility failed to implement their abuse policy in the area of investigation by not interviewing Nursing Assistant #1 who provided care to the resident on alleged abuse dates (Resident #1) for 1 of 3 residents reviewed for abuse. F 610 2/8/23 F 610 2/8/23 F 610 2/8/23 F 610 On 02/07/2023, The Regional Operations Manager educated the Administrator on investigating an abuse allegation and documentation. On 02/07/2023, the Regional Operations	F 000	INITIAL COMMENTS	3	F 00	00	
F 610 Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 record review and staff interview, the facility failed to implement their abuse policy in the area of investigation by not interviewing Nursing Assistant #1 who provided care to the resident on alleged abuse dates (Resident #1) for 1 of 3 residents reviewed for abuse. F 610 CPR(s): 483.12(c) (1) Response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c) (4) Report further potential abuse, neglect, exploitation, or mistreatment, the facility anust: §483.12(c) (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c) (4) Report further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c) (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c) (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c) (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation and other progress. §483.12(c) (4) Report further potential abuse, neglect, exploitation, or mistreatment while the investigation and ot		was conducted from Event ID# 65M011 ard intakes were investig NC00196305, NC0012 of the 7 complaint	1/17/23 through 1/23/23. and OXQJ12. The following ated NC00195636 , 196440, and NC00196900. allegations were			
neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 record review and staff interview, the facility failed to implement their abuse policy in the area of investigation by not interviewing Nursing Assistant #1 who provided care to the resident on alleged abuse dates (Resident #1) for 1 of 3 residents reviewed for abuse. On 02/07/2023, The Regional Operations Manager educated the Administrator on investigating an abuse allegation and documentation. On 02/07/2023, the Regional Operations		Investigate/Prevent/0	Correct Alleged Violation	F 61	0	2/8/23
§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 record review and staff interview, the facility failed to implement their abuse policy in the area of investigation by not interviewing Nursing Assistant #1 who provided care to the resident on alleged abuse dates (Resident #1) for 1 of 3 residents reviewed for abuse. On 02/07/2023, The Regional Operations Manager educated the Administrator on investigating an abuse allegation and documentation. On 02/07/2023, the Regional Operations		neglect, exploitation,				
neglect, exploitation, or mistreatment while the investigation is in progress. §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 record review and staff interview, the facility failed to implement their abuse policy in the area of investigation by not interviewing Nursing Assistant #1 who provided care to the resident on alleged abuse dates (Resident #1) for 1 of 3 residents reviewed for abuse. On 02/07/2023, The Regional Operations documentation. On 02/07/2023, the Regional Operations		, , , ,	•			
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 record review and staff interview, the facility failed to implement their abuse policy in the area of investigation by not interviewing Nursing Assistant #1 who provided care to the resident on alleged abuse dates (Resident #1) for 1 of 3 residents reviewed for abuse. On 02/07/2023, The Regional Operations Manager educated the Administrator on investigating an abuse allegation and documentation. On 02/07/2023, the Regional Operations		neglect, exploitation,	or mistreatment while the			
facility failed to implement their abuse policy in the area of investigation by not interviewing Nursing Assistant #1 who provided care to the resident on alleged abuse dates (Resident #1) for 1 of 3 residents reviewed for abuse. Manager educated the Administrator on investigating an abuse allegation and documentation. On 02/07/2023, the Regional Operations		investigations to the adesignated represent accordance with Stat Survey Agency, within incident, and if the all appropriate corrective. This REQUIREMENT	administrator or his or her tative and to other officials in e law, including to the State n 5 working days of the leged violation is verified e action must be taken.			
		facility failed to imple the area of investigat Nursing Assistant #1 resident on alleged a	ment their abuse policy in ion by not interviewing who provided care to the buse dates (Resident #1) for		Manager educated the Administrator investigating an abuse allegation are documentation.	or on ad
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ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

02/07/2023

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.

Electronically Signed

Facility ID: 061197

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED	
	345547 B. WING		01	C /23/2023			
NAME OF PROVIDER OR SUPPLIER CAMDEN HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 1 MARITHE COURT GREENSBORO, NC 27407		723/2023	
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 610	10/2022, read in part C. Investigation 2. Do investigation findings forms or reports. 6. A investigative process Review of the following an employee(s) is su completion of the following members (on all shift with the resident durincident. 7. General that are to be incorported include: d. Witness rewriting by the investig by both the interview. The facility had an all submitted an initial reand their investigation was a transmission eresubmitted on 12/8/2 A review of the facility 24 hours and 5 days for allegation of sexualleged that a male no inappropriately touch 11/17/22 or 11/18/22 11/22/22. The facility's investigation indicated they first be on 11/22/22. Resider (NA) #6 that there was informed Social Workships and Social Works	policy titled "Abuse" dated "Section III, Procedure: boumentation of the is maintained on applicable ctivities conducted in the include, at a minimum: a. ng: iii. Personnel records if spected or accused. b. bowing interviews: ii. (d) Staff s) who have had contact ng the period of the alleged guidelines for interviewing trated in an investigation eports are documented in gator and signed and dated er and witness." regation of sexual abuse and eport of abuse on 11/22/22 in on 11/25/22 when there error. The investigation was 22 successfully. It reported incident (FRI) at documented an investigation al abuse. The resident ursing assistant ed her vagina either on which was reported on ation report dated 11/25/22 incame aware of the incident it #1 told Nursing Assistant is a sexual pervert. The NA	F 6	Manager, reviewed all allegation abuse for the previous 3 month investigations were completed: Any concerns identified were control and education provided. Complete 02/08/2023. The Administrator was educate 02/07/2023 by the Regional Opmanager on complete document transmissions of documentation interviewing and investigation of the Regional Operations Manager on the Regional Operations of abuse of 3 months to ensure, the investigation is complete. The Regional Operations Managumentation is complete.	as to ensure thoroughly. corrected coletion d on cerations contation of con, con abuse. agerwill for the next gation and ager will Facility Meeting cone, The will		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
	345547 B. WI			01	C 01/23/2023	
NAME OF PROVIDER OR SUPPLIER CAMDEN HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP COI 1 MARITHE COURT GREENSBORO, NC 27407		12312023	
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
ared the alleged poop provided care to dings to the Admir d DON interviewed re information from termined the incidental section of the incidental se	perpetrator was a male staff of her. SW reported her nistrator. The Administrator difference and the resident #1 and received might the resident and enthappened on 11/17/22 or as a male that had provided fore. The resident was taken her than the resident's room) ed. The time was form. When asked the last en, the resident responded resident stated the NA was formal. Staff members that dent from 7:00 am to 11:00 11/17/22 and 11/18/22. The actitioner (NP) interviewed and there were inconsistencies account of the incident. The destantiated. The man interview was social Worker (SW). SW med of the abuse allegation of not remember the date. Sident #1 and reported back and Director of Nursing is not aware that a male NA and to Resident #1 and review was earlied to Resident #1 and review was and the was walking by in the hall in the recognized the man he was walking by in the hall	F 61	0			
	SUMMARY S (EACH DEFICIENT REGULATORY OR Intinued From pagared the alleged po provided care to dings to the Admin department of the proximately 8:00 per the NA was seen in glaundry. The ban and talked not be prepared for be proximately 8:00 per the NA was seen in glaundry. The ban and talked not be care of the resident and four how the Administrator DN). The SW was assigned the Administrator DN). The SW was assigned incontinence (8/22 night shift. The Administrator previously the provided carries and he provided carries man had provided is man had provided in the provided carries man had provided is man had provided in the provided carries man had provided is man had provided is man had provided in the provided carries man had provided is man had provided in the provided carries man had provided in the provided the provid	DER OR SUPPLIER LTH AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 2 ared the alleged perpetrator was a male staff or provided care to her. SW reported her dings to the Administrator. The Administrator of DON interviewed Resident #1 and received or information from the resident and termined the incident happened on 11/17/22 or 18/22. The NA was a male that had provided the area of the resident was taken another room (other than the resident's room) be prepared for bed. The time was proximately 8:00 pm. When asked the last the the NA was seen, the resident responded ing laundry. The resident stated the NA was ban and talked normal. Staff members that the value of the resident from 7:00 am to 11:00 and were females on 11/17/22 and 11/18/22. The variation of the incident. The resident and found there were inconsistencies in the resident's account of the incident. The regation was unsubstantiated. 11/18/23 at 1:41 pm an interview was inducted with the Social Worker (SW). SW ted she was informed of the abuse allegation m NA #6 but could not remember the date. The interviewed Resident #1 and reported back the Administrator and Director of Nursing ON). The SW was not aware that a male NA A #1) was assigned to Resident #1 and ovided incontinence care on 1/17/22 and	DER OR SUPPLIER LTH AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 2 ared the alleged perpetrator was a male staff o provided care to her. SW reported her dings to the Administrator. The Administrator do DON interviewed Resident #1 and received ore information from the resident and termined the incident happened on 11/17/22 or 18/22. The NA was a male that had provided ere 3 or 4 times before. The resident was taken another room (other than the resident's room) be prepared for bed. The time was proximately 8:00 pm. When asked the last the the NA was seen, the resident responded in laundry. The resident stated the NA was ban and talked normal. Staff members that the care of the resident from 7:00 am to 11:00 to were females on 11/17/22 and 11/18/22. The yehiatric Nurse Practitioner (NP) interviewed to resident and found there were inconsistencies to the resident's account of the incident. The egation was unsubstantiated. 11/18/23 at 1:41 pm an interview was anducted with the Social Worker (SW). SW teed she was informed of the abuse allegation mm NA #6 but could not remember the date. The enterviewed Resident #1 and reported back the Administrator and Director of Nursing DN). The SW was not aware that a male NA A #1) was assigned to Resident #1 and reported back the Administrator and Director of Nursing DN). The SW was not aware that a male NA A #1) was assigned to Resident #1 and reported back the Administrator provided a type-written enview of Resident #1 on 11/22/22 which was a signed. The resident recognized the man or touched her as he was walking by in the hall do he provided care on 11/17/22 and 11/18/22. Its man had provided care on 11/17/22 and 11/18/22. Its man had provided care on 11/17/22 and 11/18/22. Its man had provided care on 11/17/22 and 11/18/22. Its man had provided care on 11/17/22 and 11/18/22. Its man had provided care on 11/17/22 and 11/18/22.	DER CITION DENTIFICATION NUMBER: B. WING B. WING	DER OR SUPPLIER LTH AND REHABILITATION SUMMARY STATEMENT OF DEPICIENCES (EACH DEPICIENCY WIST SE PERCEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEPICIENCES (EACH DEPICIENCY WIST SE PERCEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 2 ared the alleged perpetrator was a male staff oprovided care to her. SW reported her dings to the Administrator. The Administrator d DON Interviewed Resident #1 and received re information from the resident and termined the incident happened on 11/17/22 or 18/22. The NA was a male that had provided e 3 or 4 times before. The resident responded ng laundy. The resident stated the NA was been and talked normal. Staff members that ks care of the resident from 7:00 am to 11:00 therefore the social Worker (SW). SW ted she was informed of the abuse allegation m NA #6 but could not remember the date, e interviewed Resident #1 and reported back the Administrator and Director of Nursing DN). The SW was not aware that a male NA A #1) was assigned to Resident #1 and voided incontinence care on 1/17/22 and 8/22 night shift. e Administrator provided a type-written enview of Resident #1 and 11/12/22 withich was signed. The resident from 11/17/22 and 11/18/23 and 1-41 and outched with the social Worker (SW). SW ted she was informed of the abuse allegation m NA #3 but could not remember the date, e interviewed Resident #1 and voided incontinence care on 1/17/22 and 8/22 night shift. e Administrator provided a type-written enview of Resident #1 and outched with the resident #1 and outched with the social Worker (SW). In the social Worker (SW) is the hall the provided care on 1/17/1/22 and bytich was signed. The resident recognized the man of bouched her as he was walking by in the hall the provided care on 1/17/1/22 and from the provided care on 1/17/1/22 and bytich was signed. The resident recognized the man of bouched her as he was walking by in the hall the provided care on 1/17/1/22 and bytich was signed. The resident recogniz	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUI IDENTIFICATION NUMBER: A. BUILD		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	345547		B. WING _			C 01/23/2023	
NAME OF PROVIDER OR SUPPLIER CAMDEN HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP COD 1 MARITHE COURT GREENSBORO, NC 27407	E	01/25/2025	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE		I SHOULD BE	(X5) COMPLETION DATE	
F 610	Continued From pag	e 3	F 6	10			
	(of furniture). The re	had a table and was barren sident stated the man was t could not describe the staff					
	1/18/23 at 2:40 pm, the hand-written list for 11/17/22 and 11/23 shifts that she intelexistent that she intelexistent to the resident reported unusual to them and interviews were not conne of the nursing sallegation nor were twith care provided to activity of daily living determine who provided to 11/17/22 and 11/18/2	need by a male nursing d that the staff were asked if any abuse or anything all answered no. The documented. She concluded staff were a suspect of the hey asked what happened the resident. The resident's record was not reviewed to ded care. e staffing schedule for 22 documented NA #1 was					
	documentation revea	#1's incontinence care aled NA #1 electronically care to the resident on					
	not on the 11/18/22 shift so he could not because the resident about 8:00 pm on 11 worked nights (11:00	ent on to say that NA #1 was schedule and worked night have been a suspect talleged the abuse occurred /17/22 or 11/18/22 and NA #1 pm to 7:00 am). The vely intact and would know tion occurred. The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345547	B. WING		01/	23/2023	
	ROVIDER OR SUPPLIER	TATION		1	IREET ADDRESS, CITY, STATE, ZIP CODE MARITHE COURT REENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689 SS=D	Administrator further a problem, was a mal was African. The Adr not aware the resider communication defici #1 (male) was on stat 11/18/22 night shift as provided incontinence Administrator stated to after the abuse allegation police.	ent on to say that the a and a history of a story was inconsistent. The stated that NA #1 never had e, and had an accent, but it ministrator stated she was at had cognitive at and was not aware that NA ff both 11/17/22 and assigned to the resident and be care both nights. The hat NA #1 resigned shortly ation investigation by the ards/Supervision/Devices		610			2/8/23
	§483.25(d) Accidents The facility must ensu §483.25(d)(1) The res as free of accident ha §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on observatio manufacturer's instru- interviews, the facility for safe mechanical li (Resident #2) for 1 of accidents. The findings included	are that - sident environment remains azards as is possible; and sident receives adequate stance devices to prevent is not met as evidenced an, record and action review, and staff failed to assess the resident fit transfer by one person 2 residents reviewed for initted to the facility on 8/6/21			On 01/09/2023, Physical Therapy Assistant(PTA) was educated by the Therapy Director that all Hoyer Mechanical Lift transfers must be done two persons. Resident #2 was not affected by this deficient practice. The PTA was interviewed on 01/09/202 by the Therapy Department and reports that he has not transferred any other residents in a lift with one person.	23	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
045547	D. MINIC	R WING		С	
NAME OF PROVIDER OR SUPPLIER				01/2	23/2023
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TATION		1 MARITHE COURT			
HAHON		GREENSBORO, NC 27407			
Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
e 5	F 6	89			
sk for falls and was by and transfer. Ission from the hospital ated 11/24/22 documented and feeling tired 7-11 days out dent was transferring and bed mobility dependent at's diagnosis was scle wasting. In an observation was done aroom. Upon entry to the did that Resident #2 was in any transferred from his by mechanical lift by the sistant (PTA). (A PTA follows the resident by the sistant to the bed when they exchanical lift transfers the ans. He stated that he used 2 to resident by mechanical lift is being transferred out of elchair because the awand if the resident swings and narrow surface (of the A stated that he transferred person) when getting him and the wheelchair because and if the resident swings he was easier." He further loes not do this" (one person)		reeducated by the Therapy De Director of Nursing or designe Hoyer Mechanical Lift transfer done by two persons. Any nursing or therapy staff who did not reeducation by 02/08/2023 will rallowed to work until this education will to the new hire education by to f Nursing on 02/08/2023. The Director of Nursing or deconduct observations 3 assist Mechanical lift transfers week weeks, than 1 weekly x 4 weemonthly x 1 month. The Director of Nursing or desbring the results of the audit to monthly Quality Assurance Cometing x 3 consecutive mont Quality Assurance Committee	epartmente that all rs must be ursing sta eceive this not be eation is all be added the Director esignee will be the committee ths. The exiting that all the enterties are the exiting the exiting the exiting the exiting the exiting that all the exiting the exiti	e aff s s s s s s s s s s s s s s s s s s	
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	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER CAMDEN HEALTH AND REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE 1 MARITHE COURT GREENSBORO, NC 27407	72020	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 689 Continued From page 6 had no problems. He made the decision to transfer the resident by himself. On 1/17/23 at 3:40 pm an interview was conducted with the Therapy Director. The Therapy Director stated she was familiar with Resident #2 and that he had the diagnosis of quadriplegia and required a mechanical lift transfer to get out of bed. The mechanical lift procedure was normally two-people assisted into and out of the bed. The Therapy Director stated that a two-people transfer was safer for this resident because he is large and dead weight and would be a risk. The therapy plan for the resident did not include mechanical lift transfer by one person. The resident was not evaluated for a one-person transfer by the PTA. She further stated that she would provide one-on-one education to the PTA to transfer this resident by mechanical lift with two staff members for safety. The PTA was an assistant to the therapy staff and the decision to transfer 1 person was not discussed with the Therapy Department for Resident #2. She stated there was a fall risk. On 1/17/23 at 4:10 pm an interview was conducted with the Administrator. She was not aware that the PTA had transferred Resident #2 by mechanical lift to by himself (1 person). No further comments were made. On 1/17/23 at 4:20 pm the manufacturer's instructions consisting of 27 pages for use of the facility's mechanical lift was provided by the Administrator. The manufacturer's instructions were reviewed which recommended 2 people for mechanical lift than provided by the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER CAMDEN HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1 MARITHE COURT GREENSBORO, NC 27407				
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F 689	operate the mechanic was a warning examp situation would need evaluation for each in caution. There were use the mechanical li interview with the Adr was not aware that the PTA not to use the alone, there should be statements were made on 1/18/23 at 3:25 pr conducted with the TR Resident #2 was not one-person use of the his quadriplegia and a people would be safe education to the staff mechanical transfer of	cal lift had 2 people. There ble use of 1 person that the a health care professional dividual case and to use no instructions on how to ft with 1 person. Concurrent ministrator: She stated she le Therapy Director wanted e mechanical lift transfer e 2 people. No further le. In an interview was herapy Director. She stated a good candidate for a le transfer device because of muscle wasting and that 2 r and would provide. A decision to make a one person would have had le Therapy staff: Physical or	F6	689			