| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345547 | A. Building<br>B. Wing | 03/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Camden Health and Rehabilitation | 1 Marithe Court<br>Greensboro, NC 27407 |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46725<br><br>Based on observations, record review, physician, Rehab Consultant Physician Assistant (PA), resident, resident family, and staff interviews the facility failed to notify the physician that Resident #114 reported he had a scheduled outpatient dental appointment. The outpatient dental appointment was for teeth extractions and the facility physician was not given the opportunity prior to the appointment to review medications or consider holding the anticoagulant medication prior to the procedure. This was for 1 of 1 residents reviewed for anticoagulant use. (Resident #114).<br><br>Findings included:<br><br>Resident #114 was admitted on [DATE] with a diagnosis of acute on chronic combined systolic (congestive and diastolic (congestive) heart failure, chronic kidney disease, diabetes, and unspecified atrial flutter.<br><br>A review of physician order dated 4/7/23 revealed an order for Eliquis 2.5 milligrams to be administered by mouth twice a day. This order was discontinued on 1/31/24.<br><br>A review of the January 2024 Medication Administration Record (MAR) revealed Resident #114 received 2.5 mg of Eliquis and was administered on 1/1/24-1/31/24.<br><br>A review of the Rehab Consultant PA note dated 1/15/24 indicated that Resident #114 reported some oral discomfort and made the Rehab Consultant PA aware of a pending outpatient dental appointment and that his son would provide the transportation to the appointment.<br><br>A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #114 was cognitively intact.<br><br>A review of Resident #114's dental patient note history on 1/25/24 revealed that Resident #114 had teeth extractions for teeth #4-10 and #15 and a bone graft on #9 and no bleeding was documented in the note.<br><br>A review of the Rehab Consultant PA note dated 1/29/24 revealed the PA noted Resident #114 upper gums were healing with no obvious bruising or bleeding observed.<br><br>(continued on next page) |

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.

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

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An observation of Resident #114 was made on 3/24/24 at 1:26 PM. Resident #114 was observed in his room sitting in wheelchair. He was alert, able to make needs known and with no signs of discomfort or bleeding of the mouth.<br><br>During an interview with Resident #114 on 3/27/24 at 11:08 AM he revealed that the facility did not stop his anticoagulant medication prior to dental extractions that occurred on 1/25/24. He further revealed that he thought he told someone at the facility about the appointment but could not recall the staff member's name.<br><br>A telephone interview was conducted with Resident #114's son on 3/27/24 at 11:12 AM. He indicated that he takes his dad out of the facility for outings and appointments on a regular basis. He further revealed he made the dental appointment and transported his dad to the appointment on 1/25/24 and did not recall making the facility aware of the dental appointment until after the appointment.<br><br>An attempt was made to interview the oral surgeon on 3/27/24 at 11:36 AM but he was not available for interview. The office manager did confirm that the oral surgeon had a list of medications on file at the time of the procedure.<br><br>A telephone interview was attempted on 3/27/24 at 1:11 PM with Nurse #3 who was assigned to this resident on 1/15/24. Nurse #3 was out on leave and did not return the phone call for interview.<br><br>An interview as conducted with the Physician on 3/27/24 at 2:39 PM revealed she was not made aware of the outpatient dental appointment or that Resident #114 had extractions until after the extractions had occurred. She further revealed if she had been made aware prior to the appointment she would have consulted with the oral surgeon and recommended holding Eliquis 3-4 days prior to the surgery.<br><br>An interview was conducted with the Rehab Consultant PA on 3/27/24 at 3:26 PM. She revealed that during her 1/15/24 visit Resident #114 made her aware he had oral discomfort and that he had an upcoming outpatient dental appointment for extractions. She further revealed that she did not make his physician aware as she assumed that the facility was already made aware by the resident and/or his son.<br><br>An interview was conducted with the Director of Nursing (DON) on 3/27/24 at 5:51 PM and she indicated that once the Rehab Consultant PA was notified of the pending dental appointment, she needed to report the information to the facility staff.<br><br>An interview was conducted with the Administrator on 3/27/24 at 5:55 PM and indicated that he would not have expected the Rehab Consultant PA to notify the facility of the outpatient dental appointment as she assumed the facility already knew of the appointment. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46725<br><br>Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of dental care for 1 of 1 residents reviewed for dental care. (Resident #89).<br><br>The findings included:<br><br>Resident #89 was admitted to the facility on [DATE] with dysphagia and unspecified severe protein-calorie malnutrition.<br><br>A review of dental consultation note dated 8/29/23 revealed resident #89 had root tips present for teeth #1,7, 8,9,12, 18, and 20.<br><br>A review of Resident #89's Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had mild cognitive impairment and to have no broken natural teeth.<br><br>A telephone interview was conducted on 3/26/24 at 3:20 PM with the dental provider. She confirmed that Resident #89 has had root tips present since 8/29/23 for teeth #1,7,8,9,12, 18, and 20 which indicated these natural teeth had been broken.<br><br>An interview was conducted with MDS nurse #1 on 03/26/24 at 3:53 PM. She revealed that she completed the dental section of the 1/4/24 significant change assessment and that she did not recall looking into Resident #89's mouth to assess the status of his teeth. She further revealed that she was not aware that Resident #89 had broken teeth and must have missed it, and it should have been coded accordingly on the 1/4/24 significant change assessment.<br><br>An interview was conducted with the Administrator on 3/27/24 at 5:54 PM and he revealed that Residents #89's significant change assessment should have reflected the resident's dental status at the time of the assessment. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38077<br><br>Based on observation, record review and interview the facility failed to: label and date foods in the walk-in and reach-in refrigerators; date opened nutritional supplements and food brought in by resident's family member in 3 of 4 Nourishment refrigerator (Nourishment refrigerator #1, Nourishment refrigerator #2 and Nourishment refrigerator #3); and maintain the ice scoop holder clean in 1 of 4 nourishment rooms (Dogwood Nourishment room). These practices had the potential to affect food served to 122 of 124 residents.<br><br>Findings included:<br><br>1 a. Observation of the walk-in refrigerator on 3/24/24 at 9:50 AM, revealed a plastic bag with 4 boiled eggs with no label, a white plastic bag with sliced meat with no label, a blue plastic bag with diced meat with no label, two individual plastic bags - one with 1/4 tomato and another with 1/2 tomato that was cut and had no label, and one plastic bag with half cut onion with no label.<br><br>During an interview on 3/24/23 at 9:51 AM, the Dietary cook stated the sliced meat in the white plastic bag was sliced turkey and was used as an alternate for the previous meal. The Dietary cook further stated the diced meat in the blue plastic bag was diced chicken. He indicated all food placed in the walk-in refrigerator should be dated with the date the food was placed in the refrigerator. The cook stated he was unsure when the tomatoes and onion were placed in the refrigerator.<br><br>1b. Observation of the reach -in refrigerator on 3/24/23 at 9:55 AM revealed a plastic pitcher 3/4th filled with a pink colored liquid dated 3/19/24. There was another plastic pitcher 1/4th filled with yellowish colored fluid with no label or date.<br><br>During an interview on 3/24/23 at 9:55 AM, the Dietary cook indicated the pink colored liquid was fruit punch. He indicated he was unsure why the pitcher containing the fruit punch was still in the refrigerator. The Dietary cook stated the yellowish fluid was lemonade, and he was unsure why it was not labeled or dated.<br><br>2. Review of the policy Food Brought by Family/ Visitor revealed perishable foods should be stored in re-sealable containers with tight fitting lids in the refrigerator. The container should be labeled with the resident's name. The policy read in part Staff will discard perishable foods on or before the use by date.<br><br>2 a. Observation of the nourishment refrigerator #1 (on Magnolia) on 3/24/24 at 10:10 AM, revealed a takeout cardboard pizza box with pizza in it with no label or date, two plastic bags with takeout food container with resident's name and room number, but no date indicating when it was placed in the refrigerator. A plastic bag containing 1/2 cheese sandwich dated 3/17.<br><br>During an interview on 3/24/24 at 10:10 AM, Nurse #1 stated any food brought in by residents' families for residents should be labeled with resident's name and date before it was placed in the nourishment refrigerator. Nurse #1 indicated the resident's family members and residents placed foods in the nourishment refrigerator without informing any staff.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2 b. Observation of the nourishment refrigerator #2 (on [NAME]) on 3/24/24 at 10:20 AM revealed a sandwich bag with half egg salad sandwich dated 3/20/24. An opened 42 fluid ounce carton labeled, 100% pure orange juice, with no date.<br><br>During an interview on 3/24/24 at 10:10 AM, Nurse Aide (NA) #1 indicated she was unsure why the orange juice carton was not dated. She stated the dietary staff were responsible for removing old sandwiches from the nourishment refrigerator.<br><br>2c. Observation of the nourishment refrigerator #3 (on Southern Rose) on 10/24/24 at 10:40 AM revealed an opened 32 fluid ounce nutritional supplement, Med Pass 2.0, with no date.<br><br>During an interview on 3/24/24 at 10:40 AM, Dietary Manager stated all opened nutritional supplements should be dated prior to placing them in the nourishment refrigerator.<br><br>3. Observation of the ice scoop holder on 3/24/24 at 10:15 AM in the nourishment room on Dogwood station revealed the ice scoop holder had white colored paper towels on the inside base of the holder. These paper towels had yellow-colored stains on them. The ice scoop was placed on these paper towels.<br><br>During an interview on 3/24/24 at 10:15 AM, NA #2 stated she was unsure who placed the paper towel in the ice scoop holder. She indicated the ice scoop was sent to the kitchen once a week to be run through the dishwasher.<br><br>During an interview on 3/26/24 at 2:30 PM, the Dietary Manager stated that all left over and opened foods should be labeled and dated prior to placement in the refrigerators or freezers. She further stated that the sandwiches in the nourishment refrigerators should be discarded after 3 days. All opened nutritional supplements should be discarded after 3 days. The Dietary Manager indicated she does a daily sweep of all nourishment refrigerators and discarded resident's food brought by families that were past 3 days or if they were spoiled. Any packaged foods were discarded per their expiration date. She indicated the dietary staff were not responsible for the labeling and dating the resident's food that were placed in the nourishment refrigerators, as the dietary staff were not aware when these foods were brought in by families or when these foods were placed in the refrigerator.<br><br>During an interview on 3/36/24 at 3:50 PM, the Director of Nursing (DON), stated nutritional supplements used on medication carts should be dated by the nursing. DON further stated occasionally the residents do put their own food or families put their food in the nourishment refrigerator without notifying the nursing staff. The nursing staff would not be able to label and date the foods that were directly placed in the nourishment refrigerator by the resident or their family members. The DON indicated nursing staff should label and date the food brought in by families if given to them to be placed in the nourishment refrigerator. The DON stated the Dietary and Housekeeping staff were responsible to ensure residents' foods in the nourishment refrigerator were labeled and dated. The DON indicated the Dietary and Housekeeping staff conduct daily sweeps of the nourishment refrigerators to ensure the food brought for the residents was within 3 days and all packaged foods were within the expiration date.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 3/27/24 at 8:21 AM, the Administrator stated the foods placed in the nourishment refrigerator should be labeled and dated, however the challenge was when the residents or resident's family members directly placed food in the nourishment refrigerator without notifying the staff. The nourishment refrigerators were checked frequently to ensure the food placed in these refrigerators was safe. The Administrator indicated the ice scoop holder had a crack on the bottom and the staff had placed paper towels to prevent water from dripping down on the floor. He indicated the entire ice scoop unit was replaced recently. The Administrator stated the ice scoop holder and ice scoop should be sent to the kitchen to be washed daily. |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>46725<br><br>Based on observations, record reviews, resident and staff interviews, the facility's Quality's Assessment and Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor the interventions that were put in place following the complaint survey conducted on 8/23/23. This was for a repeat deficiency in the area of Notification of Change (F580). This deficiency was recited during the annual recertification survey conducted on 3/27/24. The repeated citations during the two surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assessment Assurance program (QAA).<br><br>Findings included:<br><br>This tag is cross referenced to:<br><br>F 580 Based on observations, record review, physician, Rehab Consultant Physician Assistant (PA), resident, resident family, and staff interviews the facility failed to notify the physician that Resident #114 reported he had a scheduled outpatient dental appointment. The outpatient dental appointment was for teeth extractions and the facility physician was not given the opportunity prior to the appointment to review medications or consider holding the anticoagulant medication prior to the procedure. This was for 1 of 1 resident reviewed for anticoagulant use. (Resident #114).<br><br>During the recertification and complaint survey dated 8/23/23 the facility failed to notify the medical provider and resident representative after a resident, who did not have a diagnosis of diabetes or an order to receive insulin, was mistakenly administered 50/50 insulin (combination of intermediate and fast acting insulin) for 1 of 1 resident reviewed for notification.<br><br>An interview with the Administrator was conducted on 03/27/24 at 6:00 PM. He indicated that the QAPI team helps to identify areas of concern through the grievance process and weekly interdisciplinary team meetings. The data is used for root cause analysis purposes. He further revealed that his expectation was for the team to work together to maintain an effective Quality Assurance Performance Improvement Committee to ensure the facility does not repeat a previous deficient practice |