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	06/25/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews with the Pharmacist and Pharmacy Services Nurse from the dispensing pharmacy and facility staff, the facility failed to ensure medications were stored consistent with manufacturer recommendations for temperature control in 1 of 3 medication refrigerators (located in the 1100/1200 hall medication room) and in 3 of 3 medication rooms (400/500 hall, 1100/1200 hall, and 700/800 hall) observed for storage and labeling of medications. The facility also failed to label medications in 1 of 4 medication carts (400/500 hall medication cart) observed for proper storage and labeling of medications. Findings included: 1. Review of the 1100/1200 hall refrigerator temperature log form for the month of June 2026 revealed that the expected temperature range was 36-46 Fahrenheit (F) and if the temperature was not in range, one must document corrective action under the comments section of the form and recheck the temperature in one hour and record the recheck temperature on the form. If the temperature was still out of range, one would contact the nursing supervisor. The 5 temperatures out of range were recorded by Nurse #5 and Nurse #2 collectively.In the presence of the Director of Nursing (DON), an observation was made on 6/11/2026 at 8:50 AM of the medication refrigerator in the 1100/1200 hall medication room. The refrigerator's temperature was 40 F. The observation revealed that 5 of the 11 days on the temperature log form for June 2026 were recorded as: 30 F on 6/2/2026 by Nurse #2, 35 F on 6/3/2026 by Nurse #2, 35 F on 6/6/2026 by Nurse #2, 35 F on 6/7/2026 by Nurse #2, and 34 F on 6/9/2026 by Nurse #5. The refrigerator's log form had no comments or rechecks documented.An interview with Nurse #5 on 6/11/2026 at 1:56 PM confirmed she was responsible for recording refrigerator temperatures and for the medications stored in the 1100/1200 hall medication room while on shift on 6/9/2026. She said she knew if the temperature was out of the 36 to 46 F range to continue to recheck temperatures. She understood she needed to fill out the form fully and notify the manager if it was not in range. She said in June 2026 she continued to recheck the out-of-range temperatures she recorded but did not document what she did or the rechecked values. An interview with Nurse #2 on 6/11/2026 at 2:08 PM confirmed she was responsible for recording refrigerator temperatures and for the medications stored in the 1100/1200 hall medication room and that she was on shift on 6/2/2026 and she did record a temperature of 30 F. She said she did understand that if the temperature was out of the 36 to 46 F range she would continue to recheck it and if it was not in range, she would contact her manager or maintenance. She said she did recheck it on 6/2/2026 but failed to write it down on the form. She confirmed she was to write a comment and record the rechecked value, but she kept forgetting. An interview with the DON at 6/11/2026 at 8:51AM confirmed that the facility's process required the nurse to document a comment when temperatures were out of range and to contact the Unit Manager if temperatures remained out of range. If the Unit Manager could not confirm the temperature was in the acceptable range after attempts were made to cool it, then they would get maintenance involved. An interview with Nurse #3 on 6/11/2026 at 10:50 AM, revealed she was not aware of temperatures being out of range in the refrigerator in the (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1100/1200 hall medication room and was unable to provide additional information.An inventory of the refrigerator in the 1100/1200 hall medication room was conducted on 6/11/2026 at 11:44 AM. The following items were in the refrigerator: 1 box of Comirnaty (Covid-19 vaccination), 1 box of Pneumovax, 2 Trulicity (medication that is injected to help control blood sugar) boxes, 4 Lantus insulin pens, 2 Lantus insulin vials, and 1 Humulin N insulin vial. No medications stored in the refrigerator were labeled to indicate exposure to temperatures outside the manufacturer's recommended storage range. The package insert for Comirnaty stated store refrigerated at 35 F to 46 F and do not freeze. Manufacturer labeling for Pneumovax stated the vaccine should be refrigerated and instructed, Do not freeze. If frozen, discard the vaccine. The manufacturer labeling for Trulicity states it must be stored in the refrigerator at 36 F to 46 F and it must never be frozen. The manufacturer of Lantus stated store unopened insulin in the refrigerator at 36 F to 46 F and to discard if frozen. The package insert of Humulin N stated to store in the refrigerator at 36 F to 46 F and discard if frozen.An interview with the Director of Facility Services on 6/11/2026 at 9:30 AM confirmed that he had had no complaints about any refrigerators recently. He stated maintenance checks of the refrigerators were conducted monthly, and he would clean the refrigerators and did not recall any issues. In an interview with the Pharmacy Services Nurse from the dispensing pharmacy on 6/11/2026 at 1:04 PM stated, he last visited the facility on 5/19/2026. He stated he expects all medications to be properly stored at the correct temperature to ensure the quality of the medications. He confirmed he had seen the refrigerator log form on each refrigerator in the medication storage rooms. The Pharmacy Services Nurse explained as part of his duties he would carry a thermometer and check the temperature of all the refrigerators monthly. He last checked the 1100/1200 hall medication room refrigerator on 5/19/2026 and he did not report that the refrigerator was out of range. He said if the temperature was not within range he reported it to the Administrator. He expected that the refrigerator temperature would be within 36-46 F.2. Review of the facility's policy, Medication Storage with last reviewed date 1/2/2026, contained only the following verbiage on how the facility ensured medications were stored under proper temperature controls, All drugs and biologicals will be stored in locked compartments (i.e, medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. In the presence of the DON and Nurse #4, an observation of the 400/500 hall medication room was made on 6/11/2026 at 8:14 AM. The observation revealed there was no thermometer in the medication room where over-the-counter (OTC) medications and controlled medications stored in a narcotic cart were maintained.The DON and Nurse #4 stated during an interview on 6/11/2026 at 8:17 AM, that they do not monitor the temperature of the 400/500 hall medication room. They confirmed the closest thermometer was in the 400/500 hall nursing station.In the presence of the DON, an observation was made on 6/11/2026 at 8:50 AM at the 1100/1200 hall medication room that stored OTC tablets and capsules, solutions, enemas, creams and ointments, patches, and powders. A thermometer was seen on top of the refrigerator within range of 68-77 F. The DON in an interview on 6/11/2026 at 8:51 AM confirmed they do not use the thermometer in the 1100/1200 hall medication room and was unsure why the thermometer was even in there.The observation of the 700/800 hall medication room, with the DON, on 6/11/2026 at 9:09 AM revealed the thermometer displayed 81 F and a 48-hour temperature range of 79 to 82 F. The temperature on the thermometer was pointed out to the DON and the DON confirmed it read 81 F.During an interview on 6/11/2026 at 9:10 AM the DON stated that the thermometer was not used because the facility did not monitor temperatures in the 700/800 hall medication room. She then said maintenance would have more information. An observation of medications stored in the 700/800 hall medication room on 6/11/2026 at 9:22 AM revealed the room contained OTC tablets and capsules, solutions, enemas, creams and ointments, patches, and powders. The label on the bottle of aspirin tablets (used for pain relief and cardiovascular protection) stated it, must be stored at 68-77 F. A magnesium oxide (used as a mineral supplement and constipation), bottle's label stated it must be stored at room temperature, a controlled range between 68-77 F. No medications stored in the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room were labeled to indicate exposure to temperatures outside the manufacturer's recommended storage range.Review of manufacturer storage recommendations revealed aspirin tablets, magnesium oxide tablets, Biofreeze Gel (used for temporary relief of minor muscle and joint pain), Fleet Enema (used for constipation), hydrocortisone cream (used to relieve itching and swelling associated with skin irritations), athlete's foot cream (used to treat fungal skin infections), and polyethylene glycol 3350 powder (used for constipation) were recommended to be stored at a controlled room temperature of 68 to 77 F. An interview with the Director of Facility Services on 6/11/2026 at 9:30 AM confirmed that the thermometer in the 700/800 hall medication room did show that the medication room temperature was 81 F and 79-82 F for the last 48 hours. He said he was currently having a mechanic check on the air conditioning unit due to the medication room temperature being elevated. He stated that each medication room in the facility, along with the nursing office, bathroom, and nursing station in that area of the building were all under the same temperature reading in his temperature application (app) on his phone. The app will alarm if above 80 F. He confirmed he cannot monitor and isolate any medication room in the facility, and he was only monitoring the nursing station thermometer outside of the medication room. The Director of Facility Services indicated the facility's air flow was grouped into one unit in these nursing unit areas (400/500 hall, 1100/1200 hall, 700/800 hall, etc.). Each unit for the area will provide a percentage of airflow. The medication room received 20%, nursing office received 20%, bathroom received 10%, and the nursing station received 50% of the airflow. The Director of Facility Services stated the process of maintenance being notified of a temperature issue in the medication room was for the nurses to put in a work order. He said his process was to make rounds of the nursing stations to check the box for any work orders and if there was an urgent issue he would be called. The Director of Facility Services confirmed he had no complaints about the 700/800 hall medication room recently and was unsure why the thermometer inside the 700/800 hall medication room was even in the room because they do not monitor it. Observations of the 700/800 hall medication room on 6/11/2026 at 9:22 AM, 10:13 AM, and 11:37 AM revealed that the room was 81F displayed on the thermometer in the medication room. An interview with Nurse #3 at the 700/800 hall nursing station on 6/11/2026 at 10:13 AM revealed she did not know how long the medication room had been this hot. An interview with Nurse # 1 at the 700/800 hall nursing station on 6/11/2026 at 10:50 AM stated the medication room was warmer than normal and the staff does not monitor the temperature of the medication room only the refrigerator. An interview with the Administrator on 6/11/2026 at 11:00 AM stated that the air conditioning system was only an issue this morning in the 700/800 hall medication room, 6/11/2026, and that this was a new identification today. An interview in the Azelea medication room with the Director of Facility Services on 6/11/2026 at 11:37 AM revealed that he had visited the 700/800 hall medication room last Thursday (6/4/2026) and noted no issues and no work orders. He said he heard about the room temperature issues in the 700/800 hall medication room [ROOM NUMBER] days ago (6/9/2026) and he received a work order. He also stated they were working on the air conditioning now and they needed to order a part. Review of the maintenance work order request for the elevated temperature of the 700/800 hall medication room showed it was dated 6/10/2026 by a staff member with no specific name listed. Review of the air conditioning maintenance job details for the ticket for the 700/800 hall nurse station area including the 700/800 hall medication room showed that it had a start date of 6/10/2026 and end date of 6/10/2026. It stated what service was required and what service performed. An interview with the Pharmacist on 6/11/2026 at 12:45 PM confirmed her company had been servicing the facility for many years. She stated they send a Pharmacy Services Nurse from the dispensing pharmacy out to the facility monthly. The Pharmacist indicated she would expect medications to be properly stored and to follow proper guidelines to maintain temperatures to ensure the medications are being stored properly. When asked what the facility does to ensure medications were stored at the correct temperature, she stated she knows the refrigerators have daily logs, but she was unsure about the medication room. She stated that the Pharmacy Services Nurse may know. An interview with the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pharmacy Services Nurse on 6/11/2026 at 1:04 PM stated, he last visited the facility on 5/19/2026. He stated he expected all medications to be properly stored at the correct temperature to ensure the quality of the medications. The Pharmacy Services Nurse indicated he did not know how the facility ensured this for the medication rooms, but he had seen the refrigerator log form. He explained as part of his duties he would carry a thermometer and check the temperature of all the medication rooms and refrigerators monthly. The Pharmacy Services Nurse explained if the temperature of any medication room or refrigerator was not within range he reported it to the Administrator. He also stated, if the medication room was above 77 F, he would report it to the Administrator. When asked if he recalls any temperatures out of range, he stated he did have one instance recently on 5/19/2026 where they needed to remove a narcotic cart storing medications from the medication room because it was out of range. The Pharmacy Services Nurse confirmed it would appear in the report he submitted monthly to the Administrator. An interview with the Administrator on 6/11/2026 at 1:09 PM, confirmed the Pharmacy Services Nurse comes to the facility monthly. He retrieved the last report submitted by the Pharmacy Services Nurse which was dated 5/19/2026. The report stated that the 400/500 hall medication room was above 77 F and he recommended facility to temporarily move the narcotic cart out of the room. When asked how the facility was ensuring they were following their medication storage policy that states all medications, including the medication rooms, were under proper temperature controls, the Administrator stated he visited each medication room daily and he would feel if the room was fine. He stated he does not take the temperature of the medication rooms, and he also stated he does not document that he visited the medication rooms on a specific date. When asked about the thermometers in 2 of the 3 medication rooms (700/800 hall and 1100/1200 hall), the Administrator indicated they did not use them.3. In the presence of the DON, an observation was made on 6/11/2026 at 8:26 AM of the 400/500 hall medication cart. An open box of dorzolamide-timolol 2%-0.5% eye drops, used to treat ocular hypertension (a condition where the pressure inside the eye was higher than normal), dispensed for Resident #114 was stored in the medication cart. The box contained three unopened foil pouches and one opened pouch with one missing single-use container. The opened pouch was not labeled with an opened date. The DON stated that she was sure it was just opened either this morning or last night by Medication Aide #1 or Medication Aide #2. The DON stated her expectations for nursing staff were to ensure foil pouches are dated immediately upon opening. The DON took the opened pouch of eye drops and removed them from the medication cart. In an interview with Medication Aide #2 on 6/11/2026 at 2:03 PM, she said that when she opened a medication in a foil pouch, she was supposed to date it. Medication Aide #2 confirmed she administered medications to Resident #114 the previous night, 6/10/2026. She confirmed she opened a foil pouch of eye drops for Resident #114 on that shift, and she was distracted and did not go back and date it. Medication Aide #2 stated she thought she could make it to the facility on 6/11/2026 and date it then. Medication Aide #1 was present in the hall on another medication cart on 6/11/2026 at 8:26 AM and the DON asked her what do you do if you open a foil pouch and Medication Aide #1 confirmed you date it immediately. An interview with Medication Aide #1 on 6/11/2026 at 10:46 AM confirmed she understood when she opened a pouch she knew to date it. She confirmed the pouch she opened this morning for Resident #114 was dated correctly.