

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555838	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/30/2024
NAME OF PROVIDER OR SUPPLIER  Camden Postacute Care, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  1331 Camden Avenue Campbell, CA 95008	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48590</b></p> <p>Based on interview and record review, the facility failed to provide care and services in accordance with professional standard of practice for one of one resident (Resident 1) when the Licensed Vocational Nurse (LVN) did not follow the physician order regarding out on pass (leave the premises) for therapeutic therapy.</p> <p>This failure had the potential to compromise the resident's safety.</p> <p>Findings:</p> <p>Review of Resident 1's clinical record indicated she was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), neuralgia (severe, sharp, or burning pain that follows the path of a damaged or irritated nerve) and neuritis (inflammation of one or more nerves caused by injury, infection, or an autoimmune disorder causing pain, tenderness, numbness, weakness, or changes in sensation), hypertensive heart (heart problems that occur because of high blood pressure that is present over a long time) and chronic kidney disease with heart failure (a chronic condition in which the heart doesn't pump blood as well as it should).</p> <p>During a concurrent interview and record review on 7/2/24 at 1:46 p.m., with the Minimum Data Set Coordinator (MDSC), the MDSC confirmed that Resident 1 signed the facility's Out on Therapeutic Pass/Leave of Absence Log on 6/11/24 at 10:15 p.m. to go to 7-Eleven store. The MDSC stated Resident 1 became verbally and physically aggressive, so they let her go out that night and they notified the MD (physician). The MDSC stated there was no documentation in the progress notes that the MD was notified. The MDSC confirmed the physician order dated 3/21/24 indicated May go out on pass for therapeutic therapy. The MDSC stated Resident 1 going to 7-Eleven store was not considered a therapeutic therapy. The MDSC also stated Resident 1 going out to 7-Eleven store was going against the MD order.</p>

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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