F 164 SS=D 483.10(e), 483.75(1)(4) PRIVACY AND CONFIDENTIALITY

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law, third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:

Based on observations and the group interview, it was determined the facility failed to ensure the group meeting was not interrupted for five alert and oriented Random Residents attending the group meeting.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State law require it.

F164: The facility will ensure the residents right to personal privacy and confidentiality of his or her personal and clinical records.

All staff were inserviced 5/12/09 to not interrupt Resident Council meetings anytime they are in session. Resident Council Meetings will be monitored monthly and PRI by Administrator/designee to ensure privacy is maintained. Results of the monitoring will be taken to QA&A committee X 2 months for further recommendations.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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.

[Signature]

[Title]

[Date]
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 164        | Continued From page 1  
The findings included:  
Observations during the group interview conducted in the main dining room on 5/5/09 at 1:30 PM, the group was interrupted by a kitchen staff worker at 1:35 PM and a nursing staff member at 1:40 PM.  
During an interview just outside the main dining room, on 5/5/09 at 2:00 PM, the Social Worker was informed of the two interruptions and she said that she had told the staff a meeting was going on.  
483.25 QUALITY OF CARE  
Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  
This REQUIREMENT is not met as evidenced by:  
Based on medical record review, observation and interview, it was determined the facility failed to follow physician's orders for administering medication or applying heel protectors for 3 of 17 (Residents #2, 5 and 9) sampled residents.  
The findings included:  
1. Medical record review for Resident #2 documented an admission date of 11/26/08 with diagnoses of Congestive Heart Failure, Hip Fracture, Atrial Fibrillation, Hypertension, Depression, Hypopotassemia, Gout, Delusions, | F 164 | F309-The facility will ensure that each resident will receive and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  
Resident #2 orders were reviewed with no revisions noted. Resident was observed to have no negative effects.  
Resident #5 had new orders obtained on 5/5/09 to change Phenytoin pass time to 6 am and 6 pm. Resident #5 had Dilantin level drawn on 5/6/09.  
Resident #5 was assessed with no seizure activity noted. All residents on phenytoin had med pass times verified.  
Resident #9 had skin assessment done on 5/6/09 with no problems noted.  
Resident #9 orders were reviewed and revised. All other residents with heel protectors were assessed for heel protectors in place as per physician orders. All other residents will be identified through monthly order recap process. | 5/21/09 |
F 309 Continued From page 2

Hypothyroid, and a Pressure Ulcer. Review of the physician's orders dated 4/23/09 documented "...Beneprotein 2 scoops BID [twice a day] add to pudding or applesauce..."

Observations in Resident #2's room on 5/5/09 at 8:25 AM, revealed Nurse #5 mixed one (1) scoop of Beneprotein with vanilla pudding and administered it to Resident #2.

2. Medical record review for Resident #5 documented a readmission date of 10/14/08 with diagnoses of Aspiration Pneumonia, Alzheimer's Dementia, Gastrostomy, Renal Failure and Seizures. Review of the physician's orders dated 4/16/09 documented, "Phenytoin 125 mg [milligrams] / [per] 5 ml [milliliters] susp [suspension] (Phenytoin) Take 200mg (8ml) orally every morning and 100mg (4ml) at 4 PM DX [Diagnosis] Seizure Disorder." Review of the February, March, April and May, 2009 Medication Administration Records (MAR) documented Resident #5 received the Phenytoin at 6 PM not at 4 PM as ordered.

During an interview at the 100 hall nurses station, on 5/5/09 at 2:55 PM, Nurse #3 verified that the Phenytoin was administered at 6 PM.

During an interview in the Director of Nurse's (DON) office on 5/6/09 at 9:45 AM, the DON stated, "We called the MD [Medical Doctor] and had the order changed to 6 AM and 6 PM. Also had a Dilantin [Phenytoin] level drawn today."

3. Medical record review for Resident #9 documented a readmission date of 12/20/08 with diagnoses of Urinary Tract Infection, Dehydration, Leukocytosis, Methicillin Resistant

Licensed Nurses were inserviced 5/12/09 on the policy & procedure for Medication Pass with following physician orders. Medication pass with following physician order audits will be conducted 3 times per week for 4 weeks on random shifts by DNS/designee. Results of the audits will be reported to the QA&A committee for further recommendations.
<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 309             | Continued From page 3  
     Staphylococcus Aureus Naes, Hypertension, Anxiety and Gastroesophageal Reflux Disease. Review of the physician's order dated 4/18/09 documented, "HEEL PROTECTORS WHEN IN BED."  
     Observations in Resident #9's room on 5/4/09 at 2:25 PM and 2:55 PM, on 5/5/09 at 2:15 PM and 3:30 PM and on 5/6/09 at 2:15 PM revealed Resident #9 in bed with no heel protectors on as ordered.  
     During an interview outside Resident #9's room on 5/6/09 at 2:15 PM, the surveyor asked Nurse #4 if Resident #9 was supposed to wear heel protectors while in bed. Nurse #4 stated, "Yeah."  
     483.26(d) URINARY INCONTINENCE  
     Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  
     This REQUIREMENT is not met as evidenced by:  
     Based on Review of "Sorensen and Luckmann's Basic Nursing A Psychophysiologic Approach," medical record review, observation and interview, it was determined the facility failed to obtain a physician's order for a Foley catheter for 2 of 4 (Residents #10 and 17) sampled residents with a Foley catheters. | F 315-The facility will ensure based on the resident’s comprehensive assessment that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident’s clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  
     Resident #10 had catheter tubing removed off the floor on 5/6/09 and was observed to have no negative effects. All residents with catheters were assessed for tubing off the floor on 5/6/09. Resident #17 has been discharged from the facility. All residents with Foley catheters charts |
Continued From page 4

The findings included:

1. Review of "Sorensen and Luckmann's Basic Nursing A Psychophysiological Approach" third edition, page 1167, documented "...the [Foley catheter] bag and tubing must never touch the floor...These actions increase the chances for bacteria in the drainage bag to ascend the tubing and possibly to enter the bladder. Bacteria in the drainage bag can lead to UTI [urinary tract infection] and subsequent increased mucus production..."

Medical record review for Resident #10 documented an readmission date of 2/2/09 with diagnoses of Generalized Weakness, Coumadin Toxicity, Congestive Heart Failure, Anxiety, Hypertension, Constipation, Depression, Gastritis, Decubitus Ulcer and Insomnia. Review of the care plan dated 4/16/09 documented, "Keep [Foley catheter] tubing and bag off floor."

Observations in Resident #10's room on 5/5/09 at 9:30 AM, 2:15 PM and 3:30 PM revealed Resident #10 was in bed, with the Foley catheter tubing touching the floor.

During an interview in the chapel on 5/6/09 at 1:20 PM, the Director of Nursing (DON) was informed of the observations of the Foley catheter tubing being on the floor. The DON stated, "I have told them [staff], they know better than that [letting the catheter tubing touch the floor]."

2. Medical record review for Resident #17 documented an admission date of 1/16/09 with diagnoses of Right Total Knee Replacement, Supraventricular Tachycardia, Diarrhea, and were audited for Foley catheter orders on current physician recert orders on 5/13/09. All other residents will be followed with monthly order recap process. Licensed nurses were inserviced on the Policy and procedure for Foley catheter orders and care on 5/12/09. Nursing Assistants were inserviced on 5/6/09 regarding keeping catheter tubing off the floor. Charge nurses are to monitor on rounds each shift that catheter tubing is off the floor. The DNS/designee will monitor Foley catheter tubing off the floor 3 times a week for 4 weeks on random residents. Any resident with a new catheter will have the chart audited for catheter orders. Results of the monitoring will be reported to the QA&A committee for further recommendations.
F 315 Continued from page 5

During an interview in the DON's office on 5/6/09 at 9:45 AM, the DON verified there was no order that Resident #17 was to have a Foley catheter.

F 328 SS=D
483.25(k) SPECIAL NEEDS
The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, it was determined the facility failed to ensure oxygen (O2) was administered at the prescribed rate for 1 of 3 (Resident #13) sampled residents receiving oxygen.

The findings included:
Medical record review for Resident #13
**F 328**

Continued from page 6 documented an admission date of 2/1/09 with diagnoses of Dyspnea, Senile Dementia, Hypertension, and Osteoarthritis. Physician's orders dated 4/22/09 documented, "02 [liters] BNC [binaural cannula] PRN [as needed]."

Observations in Resident #13's room revealed the following:
- a. 5/4/09 at 9:00 AM - Oxygen set between 2 1/2 to 3 liters.
- b. 5/5/09 at 2:30 PM - Oxygen set at 3 liters.
- c. 5/6/09 at 8:50 AM - Oxygen set at 2.5 liters.
- d. 5/6/09 at 9:50 AM - Oxygen set at 3 liters.

During an interview at the 500 hall nurses station on 5/6/09 at 9:57 AM, Nurse #1 looked at the orders for Resident #13 and stated, "Oxygen is for 2 liters..."

During an interview in Resident #13's room on 5/6/09 at 9:58 AM, Nurse #1 looked at the oxygen setting on Resident #13 and said, "Oh, it's [O2 setting] at 2.5 liters' and proceeded to turn the oxygen setting to 2 liters.

**F 333**

**SS=D**

483.25(m)(2) MEDICATION ERRORS

The facility must ensure that residents are free of any significant medication errors.

This **REQUIREMENT** is not met as evidenced by:

Based on policy review, review of meal times, medical record review, observations and interviews, it was determined the facility failed to ensure 1 of 9 Random Residents (RR #1) observed receiving medications were free of significant medication errors by not administering sliding scale insulin within 30 minutes of a meal.

**F333** - The facility will ensure that residents are free of any significant medication errors.

Resident RR#1 orders were reviewed and insulin administration time changed to be within 30 minutes of meal time. RR#1 had no negative effects noted.

Licensed nurses were inserviced on the Policy and Procedure for insulin administration on 5/7/09. All residents with insulin had administration times for insulin audited on 5/6/09 and the times were adjusted according to meal times for insulin ordered before meals. Insulin administration audits will be conducted 3 times per week for 4 weeks on random shifts by DNS/designee. Results of the monitoring will be reported to the QA&A committee for further recommendations.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 333</td>
<td>Continued From page 7</td>
<td></td>
<td>F 333</td>
<td>Continued From page 7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The findings included:

Review of the facility’s "Insulin Characteristics" policy documented Regular (R) insulins should be administered "...30- [to] 60 minutes before a meal..."

Review of the facility's meal service schedule documented "...DINNER...TIME [tray] LINE STARTS...5:40 [PM] 200-300 HALL CART 2...TIME [meal] CART REACHES HALL...5:45/5:55 [PM]..."

Medical record review for RR #1 documented an admission date of 2/4/09 with diagnoses of Syncope, Orthostatic Hypotension, Hypokalemia, Hypothyroid, and Diabetes Mellitus. Review of the physician's orders dated 4/6/09 documented "...ACCUCHECK BID [two times a day] ...NOVOLIN R 100 UNITS/ [per] ML. [milliliter] VIAL (INSULIN REGULAR, HUMAN) INJECT PER SLIDING SCALE... [blood sugar results of] 201- [to] 250= [amount of insulin to be administered] 5U [units], 251-300=10U, 301-350=15U, 351-400=18U, > [greater than] 400=18U AND RECHECK LEVELS IN 2 HRSS [hours] IF STILL ELEVATED CALL MD [Medical Doctor]..."

Observations in RR #1's room on 5/4/09 at 4:00 PM, revealed Nurse #6 administered 5 units of Novolin R to RR #1; one hour and 45 minutes before her scheduled meal time. RR #1 was not offered a snack.

During an interview in the chapel on 5/6/09 at 1:15 PM, the Director of Nurses (DON) was asked how sliding scale insulin should be...
Continued From page 8
administered in relation to the meal times. The DON stated, "...if it's [insulin administered] more than 30 minutes before a meal, they [staff] give them a snack..." When the DON was informed that RR #1 was not given a snack with her insulin, the DON stated, "...she [Nurse #8] knew better than that..."

F 444
483.65(b)(3) PREVENTING SPREAD OF INFECTION

The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

This REQUIREMENT is not met as evidenced by:

Based on review of the "TENNESSEE CNA [Certified Nursing Assistant] Candidate Handbook Updated 01/15/2007" and observations, it was determined the facility failed to ensure staff washed their hands after performing tasks that provided the opportunity for cross-contamination among individuals during 1 of 1 (breakfast) dining observations.

The findings included:

Review of the "TENNESSEE CNA Candidate Handbook Updated 01/15/2007" (page 8), documented, "...Skill 1 - Handwashing ...4. Wets hands... 10. Dries hands on clear paper towel(s). 11. Turns off faucet with a SECOND (last) clean dry paper towel ...13. Does not re-contaminate hands at any point during the procedure." Observations of the breakfast meal on the 500 hall, on 5/5/09 at 7:40 AM, revealed CNA #1
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>FRAGMENT</th>
</tr>
</thead>
</table>
| F444 | Continued From page 9  
  washed her hands, turned off the faucet and then dried her hands with a paper towel.  
  
  Observations of the breakfast meal on the 500 hall, on 5/5/09 at 7:48 AM, revealed CNA #2 washed her hands, dried her hands with a paper towel, turned off the water faucet, and then wiped her hands and arms using the same paper towel.  
  483.75(I)(1) CLINICAL RECORDS  
  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  
  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  
  This REQUIREMENT is not met as evidenced by:  
  Based on policy review, medical record review, observation and interview, it was determined the facility failed to maintain accurate medical records for alarms, diets, behavior flow sheets, intake and output (I&O) or Foley catheter care for 6 of 17 (Residents #1, 3, 5, 7, 11 and 13) sampled residents.  
  The findings included:  
  1. Medical record review for Resident #1 documented a readmission date of 3/2/09 with diagnoses of Senile Dementia, Osteoporosis, |
| F514 | SS=E  
  483.75(I)(1) CLINICAL RECORDS  
  The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  
  Resident #1 had new order obtained to discontinue mat alarm to bed on 5/7/09. Resident #1 was observed to have no negative effects. Resident #3 had order obtained to discontinue HS snack on 5/7/09. Resident #3 was observed to have no negative effects. Resident #5 had physician order obtained on 5/5/09 for Phenytoin to be given 6 am and 6 pm per PEG. Resident #5 was noted to have no seizure activity and no negative effects. Resident #7 had order obtained to change diet to regular on 5/6/09. Resident #7 was observed to have no negative effects. Resident #1 had behavior changed on Behavior Monitoring sheet from Seizures to hitting, spitting, and pinching on 5/5/09. Resident #11 had I&O |
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 514         | Continued From page 10 Compression Fracture of Lumbar Spine and Depression. A physician's telephone order dated 4/6/09 documented, "DC [Discontinue] mat alarm to bed." Review of the current physician recertification orders signed 4/9/09 documented, "Mat alarm while in bed to remind res. [resident] to call for assist when getting up." Observations in Resident #1's room on 5/4/09 at 9:20 AM and at 12:51 PM, revealed there was no mat alarm on the bed. During an interview in the Director of Nurse's (DON) office on 5/6/09 at 9:45 AM, the DON verified that Resident #1 did not have a mat alarm. 2. Medical record review for Resident #3 documented a readmission date of 10/30/08 with diagnoses of Vegetative State, Quadriplegic, Disorder of the Bladder, Convulsions and Depressive Disorder. A physician's order dated 4/16/09 documented, "...DIET ORDERS NPO [nothing by mouth] ...HS [hour of sleep] SNACK EVERY EVENING."
|               | F 514 discontinued 5/11/09 due to order for “Comfort measures only.” Resident #11 was observed to have no negative effects. Resident #13 had Foley catheter discontinued on 4/27/09. Resident #13 was observed to have no negative effects. Residents with tube feedings had recent orders audited for HS snack orders on 5/7/09. Behavior monitoring sheets were audited for appropriate behaviors on 5/13/09 and updated as appropriate. All residents with Foley catheters had Treatment sheets audited for Foley care daily on 5/7/09 and 5/13/09. Residents with I&O sheets were audited for blanks on 5/7/09 and 5/13/09. Residents #1, 3, 5, 7, 11, & 13 have had current physician recent orders updated with revised orders 5/13/09. All other residents will be updated by facility monthly order recap process. All residents’ recent physician orders will be audited monthly time 2 months by DNS/designee. Results of the audit for recent physician orders will be reported to the QA&A committee for 2 months for further recommendations. |               |                                 |                |
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PROVIDER/SUPPLIER/COLA IDENTIFICATION NUMBER: 445274

MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

DATE SURVEY COMPLETED: 05/06/2009

NAME OF PROVIDER OR SUPPLIER
CAMDEN HLTHCARE & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
197 HOSPITAL DR
CAMDEN, TN 38320

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LTC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 514</td>
<td>Continued From page 11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>200mg (8ml) orally every morning and 100mg (4ml) at 4 PM DX [Diagnosis]: Seizure Disorder.</td>
<td></td>
</tr>
</tbody>
</table>

During an interview in the 100 hallway on 5/5/09 at 7:48 AM, Nurse #2 stated, "She [Resident #5] gets all her meds [medications] by PEG [Percutaneous Endoscopic Gastrostomy]."


Observations in the main dining room on 5/5/09 at 7:35 AM and 11:50 AM and on 5/6/09 at 12:10 PM, revealed Resident #7 eating a regular diet.

During an interview in the chapel on 5/6/09 at 12:30 PM, the DON was shown the orders as documented above. The DON stated, "She [Nurse] should have transcribed that order [regular diet]."

5. Medical record review for Resident #11 documented a readmission date of 11/30/08 with diagnoses of Senile Dementia, Gastroesophageal Reflux, Paranoid Schizophrenia, Neurosis and Psychosis. Review of the "Behavior/Intervention Monthly Flow Record" dated March and April, 2009 documented the following: "Haloperidol [an antipsychotic medication] 0.5 mg tablet Hydroxyzine HCl 25 mg tablet DIRECTIONS: Enter target behavior in one of the Behavior Sections. Record the number of episodes by shift..."
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 514</td>
<td>Continued From page 12 with initials. Enter the Intervention Code, Outcome Code and Side Effects Codes with initials for each shift. See side two for list of behavior and potential side effects.&quot; The behavior to monitor for March and April, 2009 was &quot;Seizures&quot;. During an interview at the 100 hall nurses station on 5/5/09 at 2:51 PM, Nurse #2 stated, &quot;Seizures not behavior, it's [Haloperidol] for hitting, spitting and pinching.&quot;</td>
<td>F 514</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID PREFIX TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>COMPLETION DATE</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
<td>---------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
</tbody>
</table>
| F 514         | Continued From page 13  
Foley Cath.” Review of the medication record dated 4/22/09 through 4/30/09 documented, “FC [Foley care] q day et [and] pm [as needed]...”  
During an interview in the DON's office on 5/5/09 at 3:30 PM, the DON was asked if the documentation of the Foley care indicated that no Foley care was done from 4/23/09 through 4/27/09. The DON stated that she would check the Certified Nurse Assistant (CNA) record.  
During an interview in the chapel on 5/5/09 at 4:00 PM, the DON showed the surveyor the CNA record which indicated that care had been done and said that the medication record did not indicate the correct care given.  
The facility failed to ensure Residents #1, 3, 5, 7, 11 and 13's medical records were accurate. | F 514 | |
| (X1) PROVIDER/SUPPLIER/CLA ID NUMBER: 445274 | (X2) MULTIPLE CONSTRUCTION A. BUILDING  | (X3) DATE SURVEY COMPLETED: 05/06/2009 | STREET ADDRESS, CITY, STATE, ZIP CODE 197 HOSPITAL DR CAMDEN, TN 38320 | |
| NAME OF PROVIDER OR SUPPLIER CAMDEN HLTHCARE & REHAB CENTER | |
| (X4) ID PREFIX TAG | |
| | | | | |

FORM CMS-2587(02-99) Previous Versions Obsolete  
Event ID: 10LB11  
Facility ID: TN0302  
If continuation sheet Page 14 of 14