

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445274	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Camden Healthcare & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 197 Hospital Drive Camden, TN 38320	

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 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to ensure a resident received adaptive devices as ordered by the physician for 1 of 3 (Resident #15) sampled residents reviewed for nutrition.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Use of Assistive Devices, revised 10/26/2023, revealed .The purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function and/or dignity .Assistive devices are tools, products, types of equipment, or technology that help individuals perform tasks and activities. They may help the individual .eat .Assistive devices include .eating utensils .The facility will provide assistive devices for residents who need them .The resident's assigned nurse will monitor for the consistent use of the device .</p> <p>2. Review of the medical record revealed Resident #15 was admitted to the facility on [DATE], with diagnoses including Parkinson's Disease, Postural Kyphosis, Anxiety, and Tremor.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 9, which indicated Resident #15 was moderately cognitively impaired.</p> <p>Review of the Care Plan dated 2/27/2025, revealed .Resident [#15] has an impaired neurological status related to dementia, Parkinson's Disease .Administer medications and treatments as indicated by orders . Provide assistance with meals as needed .</p> <p>Review of the Physician's Orders dated 3/26/2025, revealed .Pt. [Patient/Resident #15] to have divider plate and 2 handled cup at meals to reduce food spillage at meals .</p> <p>During observation and interview in the resident's room on 4/28/2025 at 10:00 AM, Resident #15 exhibited tremors in both arms and hands. Resident #15 stated, .I spilled my drink and stopped eating because I was spilling things .</p> <p>Observation in the resident's room on 4/28/2025 at 12:02 PM, revealed a cup with no handles on Resident #15's tray. Resident #15 grabbed the cup with no handles with both hands and spilled the drink.</p> <p>(continued on next page)</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
-----------------------------------------------------------------------	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445274	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Camden Healthcare & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 197 Hospital Drive Camden, TN 38320	

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 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the [NAME] (system for documenting and organizing patient information) Report dated 4/30/2025, revealed .Provide adaptive equipment: (2 handled cup .).</p> <p>Review of the Meal Card dated 4/30/2025, revealed .Two Handled Cup .</p> <p>Observation in the resident's room on 5/1/2025 at 8:02 AM, revealed the cups on Resident #15's breakfast tray had no handles.</p> <p>During an interview on 5/1/2025 at 8:05 AM, Certified Nursing Assistant (CNA) H confirmed that Resident #15 was supposed to have a two handled Cup.</p> <p>During interview on 5/1/2025 at 2:02 PM, the Assistant Director of Nursing (ADON) confirmed staff should follow the physician's orders.</p> <p>Observation in the resident's room on 5/1/2025 at 5:47 PM, revealed the cups on Resident #15's dinner tray had no handles.</p> <p>During an interview on 5/1/2025 at 5:49 PM, the ADON confirmed staff should provide adaptive equipment at mealtime if the physician had ordered it.</p> <p>During an interview on 5/1/2025 at 5:50 PM, the Dietary Manager (DM) confirmed the facility had enough Two Handled Cups to provide for their residents.</p>