DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	C 05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET ST GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interviews, and facility and medical record review, the facility failed to ensure the correct transfer technique was used for one (1) of (4) residents (Resident #2). The findings are: Resident #2 was admitted to the facility with diagnoses of muscle weakness, congestive heart failure, and legal blindness. The latest Minimum Data Set dated 03/15/12 revealed the resident had severe cognitive impairment and required the assistance of two or more staff for transfers. Review of the resident's care plan, revised 03/16/12, revealed that the resident was assessed to require two persons to assist with all transfers. On 04/05/12 the care plan was again revised to require the use of a mechanical lift for all transfers. a.) A facility investigation report of a fall by Resident #2 was reviewed. The report revealed that on 03/25/12 Nursing Assistant (NA) #1 was transfered the resident by herself from the toilet to the wheelchair when Resident #2 fell to the floor.	F 323	To correct the cited deficiency for fall prevention procedures the following systems and processes were revised and action taken to ensure fall prevention protocols were maintained. Ongoing education given to staff with on-the-spot education/training given to C.N.A.'S, Med Aides and Restorative Aides by Hall Nurse and/or SDC when a need was identified. Safeguards and any correction in the Care Plan were unable to be implemented for resident #2 as resident was discharged to another nursing home at the request of the daughter and power of attorney. 6/1/2012 To correct the cited deficiency the following action was taken: 1) C.N.A.'s 1,2,3 and 4 were all re-educated at the time of the occurrence with a written and/or verbal disciplinary warning on 3/25/2012, 4/4/2012 and 5/10/2012. 2) A Dementia program was implemented and is held daily from 3 p.m. to 5 p.m. 5/30/2012 All Direct Care Staff will be required to attend a mandatory Inservice prior to 6/25/2012 for compliance with protocols for fall prevention: 1) Transfer protocols with emphasis on explanation of procedure to resident prior to and during procedures. 2) Ensuring proper equipment utilization, i.e. splints, braces, cushions, low beds, floor mats, alarms, etc., 3) Compliance with Toileting schedule 4) ADL documentation. 5) Safety during bathing in shower rooms or while resident toileting. 6) Timely response to call bells 7) Water pitchers and call bells within reach of resident. 8) To ensure that updated care plan worksheets are given to C.N.A.'s, Med Aides and Restorative staff at beginning of each shift. 6/25/2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandy E Ward — TITLE: RN DON — (X6) DATE: 6/22/12

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.

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JUN 25 2012
BY:

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F 323	Continued From page 1 She received a hematoma to her right elbow which was treated with an ice pack. The report further indicated that NA #1 should have used the assistance of another staff member for the transfer. On 05/31/12 at 2:55 PM, NA #1 was interviewed. She stated that on 03/25/12 she had attempted to transfer the resident by herself from the toilet to the wheelchair, but Resident #2 tried to sit down before she got the wheelchair in place and locked. The resident hit the edge of the wheelchair seat and then went to the floor. NA #1 stated that all NAs carried a copy of the Care Plan Report which included specific instructions for transferring each resident. She stated that NAs were supposed to refer to these instructions each day before transfers, but she did not look at the instructions for this resident before she transferred her. b.) A second facility investigation report of a fall by Resident #2 was reviewed. The report revealed that on 04/04/12 Nursing Assistant (NA) #2 was using a gait belt to transfer the resident by herself from her bed to the wheelchair when she had to lower Resident #2 to the floor with the gait belt. Resident #2 received no injuries during the fall. On 05/31/12 at 3:28 PM, NA #2 was interviewed. She stated that on 04/04/12 she had attempted to transfer the resident by herself from the bed to the wheelchair. She stated she thought she had locked the wheelchair, but one lock had not fully engaged because it was striking the footrest. NA #2 stated that when the resident began to sit in the wheelchair, it moved and she had to safely	F 323	To correct the cited deficiency the following procedures will be implemented. 1) A C.N.A. team Leader will be scheduled for each hall on each shift by the SDC. 2) Team Leader responsibilities will be to coordinate with the Hall Nurse at the beginning of each shift to distribute updated care plan worksheets and make rounds with all outgoing C.N.A.'s, Medication Aides and restorative aides at the beginning of each shift to ensure all updated care plans are reviewed during rounds. Hall Nurse Responsibilities: 1) Hall Nurse will ensure care plan worksheets are distributed to the C.N.A.s, Med Aides and Restorative Aides at the beginning of each shift. 2) Hall Nurse will conduct Nursing Rounds x 4 each shift to monitor compliance with protocols related to transfers, toileting, proper equipment utilization safety during bathing in shower and while toileting, compliance with use of care plans, call light response and call bells in place and water within reach of the of the resident. 3) Hall Nurse will audit all ADL's documentation at the end of each shift. 4) Hall Nurse and/or SDC will give on-the-spot education/training to nursing staff, C.N.A.'s Med. Aides, and Restorative Staff for any deficient practices identified. A Nursing QAA Fall Prevention monitoring check sheet has been developed and will be utilized to audit all protocols established for fall prevention. ADON, DON, MDS and Treatment Nurse will each monitor a hall and audit at least 6 residents each shift dally x 1 month. Twice weekly x 1 month, weekly x 1 month and continue monthly monitoring as part of the nursing QAA indicator set. ADON will continue to educate on transfers during monthly staff meetings.	6/25/2012

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F 323	Continued From page 2 lower the resident to the floor using the gait belt which she had placed around the resident's waist. She stated the resident was not injured. NA #2 stated the NAs carried a daily Care Plan Report which contained information on the required number of staff for each resident transfer. She stated she had not looked at the report before that transfer because she had forgotten to pick up her Care Plan Report at the beginning of the shift. c.) A third facility investigation report of a fall by Resident #2 was reviewed. The report revealed that on 05/10/12 Nursing Assistants (NA) #3 and #4 assisted Resident #2 to the toilet and then back to her wheelchair. Once in the wheelchair the resident pitched forward, fell out of the wheelchair, and struck the left side of her face on the floor, receiving a hematoma and scrape under her left eye which were cleaned and treated with an ice pack. On 05/31/12 at 1:54 PM, NAs #3 and #4 were interviewed. The NAs confirmed that Resident #2 had fallen on 05/10/12 when they were transferring her from the toilet to the wheelchair. NA #3 stated that the Care Plan Report for Resident #2 indicated a mechanical lift should be used for all transfers, but she had been told that day by a nurse that the resident could be toileted by two staff without the use of the lift. NA #3 could not remember who told her this. Both NAs confirmed that they did not engage the wheelchair brakes before this transfer. Once the resident was in the wheelchair, NA #3 stated she started around the wheelchair to straighten up the resident who was not seated all the way back. NA #3 stated before she could get behind the wheelchair, Resident #2 pushed on the floor with	F 323	DON or designee will review results of audits daily with interdisciplinary team members at the morning meeting to review trends, effectiveness of audit and need for any system changes. DON or designee will compile results of audits quarterly and report findings, recommendations action and follow-up needed to the QAA Committee	

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F 323	Continued From page 3 her feet to scoot herself back. The unlocked wheelchair moved backwards and the resident pitched forward onto the floor. Both NAs #3 and #4 stated they should have used the mechanical lift and locked the wheelchair brakes. On 05/31/12 at 4:10 PM the Director of Nursing (DON) was interviewed. She stated that the Care Plan Report carried by NAs indicated the type of transfer required for each resident and was revised as needed daily. The DON stated all NAs had been inserviced to refer to the report daily before transfers and she expected them to. She stated NA #1, #2, #3, and #4 should have reviewed the Care Plan Report and used the required number of staff and equipment for the transfers when the falls occurred. The DON also stated the wheelchair brakes should be locked before any transfer.	F 323		