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 09/28/2012

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 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to provide treatment to pressure ulcers to prevent infection for one (1) of three (3) residents observed for pressure ulcers. Resident #5 The findings are: Resident #5 was admitted to the facility originally 06/08/12. His current diagnoses included quadriplegia, urinary incontinence, and pressure ulcers. Review of the resident's most recent Admission Minimum Data Set dated 09/02/12 revealed he was cognitively intact and was dependent on staff for all activities of daily living. A laboratory result dated 08/14/12, revealed he was screened for methicillin-resistant Staphylococcus aureus (MRSA). This test result was positive for MRSA colonized in nares. Review of physician orders dated 09/15/12 revealed an order for wet to dry dressings with	F 314	To address the deficient practice related to resident #5, Nurse #1 was given a written/verbal re-education on standard infection control techniques to prevent contamination of an open wound The written plan stated that the re-education on 9/28/2012 for Nurse #1 will be monitored for correct wound care technique with each dressing change performed x 4 weeks, then will be observed weekly x 4 weeks, then monthly x 4 months by Staff Development Coordinator and/or Charge Nurse and report documented results to the ADON and/or DON.	9/28/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Janel B Eckard	RN DON	10/12/12

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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F 314	Continued From page 1 Vancomycin soaked gauze (1 gram to 250 cubic centimeters normal saline) packed into wounds on bilateral heels. Review of the facility's wound documentation dated 09/20/12 revealed Resident #5 had pressure ulcers on both right and left heels and on the inner right ankle. This documentation showed the wounds on his heels had increased in size from 09/11/12 to 09/20/12. The pressure ulcer on right inner ankle was acquired on 09/19/12. During an observation on 09/28/12 at 9:10 AM of care the resident had a loose liquid bowel movement. During the observation of care he also urinated a large amount soaking the sheet under him. The nursing assistants placed a dry pad under the resident's buttocks and upper body. The soiled sheet below the buttocks was still exposed. While providing his morning care the nursing assistants removed the foam boots from the resident's feet. The resident was observed to have dressings on both heels. While the nursing assistants were providing care the resident was drawing his legs up with his heels close to his buttocks. His heel dressings became soaked with urine and loose stool. After dressing the resident the nursing assistants left the resident in bed so nursing could change his dressings. An observation was made on 09/28/12 at 9:50 AM of dressing changes performed by Nurse #1 who was assisted by a nursing assistant. Nurse #1 removed the dressing from Resident #5's left heel while the nursing assistant held his foot up. The old dressing was placed in a trash bag.	F 314	All Nurses, NAII,s and Medication Aides have been re-educated on proper techniques of wound care with concentration on standard infection control techniques to prevent contamination of an open wound. Monitoring for correct wound care technique with each dressing change performed x 4 weeks, then will be observed weekly x 4 weeks, then monthly x 4 months by Staff Development Coordinator and/or Charge Nurse and report documented results to the ADON and/or DON. The DON will review compliance daily x 4 weeks in the morning interdisciplinary meeting and then will compile results with needed action plan for the quarterly QAPI Committee. To address how corrective action will be accomplished for those residents having potential to be affected by the deficient practice, wound packages that include dressing supplies have been set up on each treatment cart that are resident specific. The package includes a clean disposable pad to provide a clean barrier for each wound. The Treatment Aide (NAII) has the responsibility to compile the packages on a weekly basis and as needed The Charge Nurse will oversee the process for compliance and report any discrepancies to the Staff Development Coordinator.	10/12/2012 10/12/2012 10/12/2012

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F 314	Continued From page 2 Nurse #1 then readied her supplies of medicine cups filled with normal saline and Vancomycin solution. The nursing assistant then placed the resident's left foot on the bed sheet with the open wound touching the soiled sheet. The nurse then cleaned the heel wound with normal saline, foot again placed down on the soiled bed sheet. Vanomycin soaked gauze was applied to the wound and covered with dry gauze. While the nurse opened the roll gauze the resident's foot was sat down on bed the entire dressing fell off and again the wound touched the soiled bed sheet. The entire process was repeated this time with out the wound touching the bed sheet. While Nurse #1 prepared dressing supplies for the right heel the nursing assistant place a towel under Resident #5's foot. The urine/stool soaked dressing made a mark on the towel. Nurse #1 then removed the old dressing and placed the foot with the wound directly touching the soiled towel. The wound on the right heel and right ankle were cleaned with normal saline and Vancomycin gauze packed into wounds covered with dry dressing and wrapped with roll gauze. An interview was conducted with Nurse #1 on 09/28/12 at 10:38 AM. Nurse #1 stated the resident's heel wounds should not have touched the soiled sheet or towel. She stated a clean barrier should have been placed under the resident ' s feet so the heel wounds would not have touched the contaminated sheet or towel. An interview was conducted on 09/28/12 at 11:13 AM with the Director of Nursing (DON). The DON stated the nurse should have place a clean barrier under the resident ' s feet to protect the wounds from touching the contaminated sheet	F 314	A quarterly report on the wound treatment procedures for compliance with infection control practices will be presented by the Staff Development Coordinator as part of the Infection Control/Wound Report to the QAPI Committee until substantial compliance is sustained over a 1 year period .	

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F 314	Continued From page 3 and towel. The DON further stated Resident #5 had previously tested positive for MRSA and that is why the resident ' s wounds were being treated with Vancomycin.	F 314		