

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

PRINTED: 11/27/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345246	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/08/2012
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NAME OF PROVIDER OR SUPPLIER  CAMELOT MANOR NURSING CARE FAC	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET ST GRANITE FALLS, NC 28630
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(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 242 SS=D	<p><b>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</b></p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to accommodate a resident's preference for frequency of showers and time to get up in the morning for 3 of 13 residents (Resident #53, #28, and #81).</p> <p>The findings are:</p> <p>1. Resident #53 was admitted with diagnoses including congestive heart failure, arthritis, and diabetes mellitus. Her most recent Minimum Data Set assessment indicated moderately impaired cognition with the ability to understand others and be understood. Resident #53 required extensive two person assistance with bed mobility, transfers, toileting and extensive one person assistance with bathing.</p> <p>A medical record review revealed a Nursing Admission Assessment dated 08/09/12 with a stated preference for bathing three times a week by showers. A Social History dated 08/16/12 revealed the resident to be alert, able to voice needs and able to participate in decision making.</p>	F 242	<p>To correct the cited deficiency for facility failure to accommodate a resident's preference for frequency of showers and time to get up in the morning, the following correction plans were put in place:</p> <p>Residents #53 and #81 are now scheduled for three showers a week.</p> <p>Nurses will be responsible for documentation of any deviation from the plan of care in the medical record, i.e. refusal of shower.</p> <p>Mandatory education for all nursing personnel on "Rights for Residents to Make Choices" completed by the D.O.N.</p> <p>Admission Assessment was reviewed and improved to document shower preferences on admission by the D.O.N.</p> <p>Preferences will be reviewed on all new admission/readmissions in the daily interdisciplinary morning team meeting.</p> <p>The resident's preference will then be placed on the plan of care and the Daily Nursing Worksheet by the MDS Coordinator.</p> <p>The Care Plan team will meet with the resident, family and/or responsible party within 14 days of admission to discuss plan of care and any issues identified.</p> <p>Resident preferences will continue to be reviewed and documented as part of the quarterly care planning meeting.</p>	<p>11/9/2012</p> <p>11/9/2012</p> <p>11/14/2012 12/6/2012</p> <p>11/14/2012</p> <p>12/14/2012</p> <p>12/14/2012</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Sandy E. Howard*

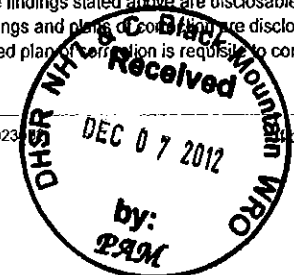
TITLE

*RN DON*

(X6) DATE

*11/6/12*

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 required to continued program participation.



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F 242	<p>Continued From page 1</p> <p>An interview with Resident #53 on 11/06/12 at 9:33 AM revealed the resident received one shower and a bed bath each week on scheduled days. During a subsequent interview on 11/07/12 at 3:14 PM Resident #53 stated she should be able to choose how often she received a shower and if staff knew how good it made her feel they would not mind accommodating her choice. Another interview with Resident #53 on 11/08/12 at 3:00 PM revealed her preference for three showers a week had not changed but she stated one of the bathing times could be a bed bath.</p> <p>An interview with the Director of Nursing (DON) on 11/08/12 at 4:20 PM revealed her expectation that resident preferences assessed during the admission process be discussed at the morning meeting the day following admission. The DON stated if a resident's preference for bathing frequency was discussed during care planning meetings it was accommodated.</p> <p>2. Resident #28 was admitted to the facility on 3/15/06. Her most recent Minimum Data Set (MDS) assessment indicated she was cognitively intact and able to understand others and be understood.</p> <p>An interview with Resident #28 on 11/06/12 at 10:15 AM revealed the resident was awakened very early by staff each morning. When asked if she told staff she'd like to stay in bed longer, the resident reported staff made her get up early each morning, even when she requested to stay in bed longer.</p> <p>The Admission Assessment for Resident #28 does not indicate the resident's preference for</p>	F 242	<p>All current residents that have the capacity to make decisions will be asked about their shower preferences and their preferences will be documented and implemented.</p> <p>All current residents will then be reviewed on a quarterly basis as part of the care planning process.</p> <p>The facility will monitor its performance weekly by review of each admission/readmission, in the morning interdisciplinary meeting and by the Charge Nurse follow-up on the 7<sup>th</sup> day following admission/readmission.</p> <p>The Care Plan team will document the meeting with resident, family and/or responsible party regarding resident choices on the 14<sup>th</sup> day following admission/readmission on the Interdisciplinary Care Plan Conference Record.</p> <p>The Charge Nurse will document any deviations from the plan of care in the medical record.</p> <p>The Medical Record Clerk will audit the chart for compliance with documentation of individual resident preferences by the Charge Nurse and the care planning team monthly x 3 months and then quarterly x 6 months</p> <p>Report will be reviewed by the QAPI Committee on a quarterly basis to determine compliance.</p> <p>Resident #28 current get-up time and her preference for awakening in the morning was reviewed.</p>	<p>12/6/2012</p> <p>12/14/2012</p> <p>12/14/2012</p> <p>12/14/2012</p>

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F 242	Continued From page 2 time she would like to get up each morning.  Interview with Nurse #1 on 11/08/12 at 10:30 AM revealed residents are assigned to get up at either 6:00 AM or 7:00 AM depending on their dining room breakfast assignment.  Interview with the Director of Nursing on 11/08/12 at 11:30 AM revealed the residents who get up earliest are the residents who have not expressed preferences and are the residents who are to be served during the first breakfast seating in the dining room.  Interview with MDS Coordinator on 11/08/12 at 2:45 PM revealed she created the list of residents who are awakened at 6:00 AM, including Resident #28, based on the length of time it takes for the nurse aides (NAs) to get residents up and groomed for breakfast. The MDS Coordinator also reported that a certain amount of residents have to get up before 7:00 AM so that there will be enough staff available to get all residents up in time for breakfast. The MDS Coordinator further stated the third shift NAs get up the residents who are assigned to get up at 6:00 AM and first shift (7:00 AM to 3:00 PM) NAs get up the residents who are assigned to get up at 7:00 AM.  3. Resident #81 was readmitted to the facility on 04/11/12. Her most recent Minimum Data Set (MDS) assessment indicated she was cognitively intact and able to understand others and be understood.  An interview with Resident #81 on 11/06/12 at 11:34 AM revealed the resident gets two showers each week but would prefer to get three showers	F 242	Discussed preference with care plan team and added residents name to the "get up" schedule that accommodates the resident's preference.  Admission Assessment reviewed and revised to include information of resident's normal time of awakening in the morning.  Mandatory education for all nursing personnel that explains the "The right for residents to make choices" was completed  Preferences for a time to get up will be reviewed on all new admissions/readmissions in the daily interdisciplinary morning team meeting. Preferences will then be placed on the plan of care and resident will then be added to the appropriate get up schedule.  The Care Plan team will document the meeting with resident, family and/or responsible party regarding resident choices on the 14 <sup>th</sup> day following admission/readmission on the Interdisciplinary Care Plan Conference Record.  All residents that have the capability of making choices will be interviewed for awakening preferences and will then be reviewed quarterly with the care plan schedule thereafter.  The facility will monitor its performance weekly by reviewing each new admission/readmission's choice of time of awakening in the daily interdisciplinary meeting following admission/readmission.	11/14/2012  11/14/2012  11/14/2012  12/14/2012  12/14/2012  12/14/2012	

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F 242	Continued From page 3 each week.  An interview with the Director of Nursing (DON) on 11/08/12 at 11:30 AM revealed all showers for residents are set up for two days a week unless they request something different. The DON stated shower preferences are checked and documented on the admission assessment and also by the MDS Coordinator and the Social Worker during each quarterly MDS assessment (every three months).  The Readmission Assessment for Resident #81 revealed a preference for showers but did not indicate the resident's preference regarding frequency of showers per week.  Interview with the Social Worker revealed shower preferences are assessed by the nursing staff and not by social workers. The Social Worker reported if the resident or family offered information to her about their shower preferences, she passed that information on to nursing staff, but it did not fit in the social work assessment.  Interview with the MDS Coordinator on 11/08/12 at 2:45 PM revealed she assigned shower days and frequency to residents based on the room to which they are assigned. The MDS Coordinator reported all showers are scheduled according to room numbers and when a resident moves, their shower days change, according to their new room number. The MDS Coordinator further stated shower frequency preferences were only assessed during the admission assessment.	F 242	The get up schedule will reflect compliance with resident choice of awakening and get up time.  The Charge Nurse will document by the 7 <sup>th</sup> day of admission/readmission compliance with or deviation with individual choice and/or change of preference in the medical record.  The Medical Record Clerk will audit the chart for compliance with documentation of individual resident preferences by the Charge Nurse and the care planning team monthly x 3 months and then quarterly x 6 months.  Report will be reviewed by the QAPI Committee on a quarterly basis to determine continued compliance	12/14/2012  12/14/2012  12/14/2012
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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F 281	<p>Continued From page 4</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to obtain a Physician ordered laboratory test for 1 of 10 residents (Resident #13).</p> <p>The findings are:</p> <p>Resident #13 was admitted with diagnoses including coronary artery disease and hyperlipidemia.</p> <p>A medical record review revealed a current order for atorvastatin calcium (brand named Lipitor), a medication used to decrease the amount of cholesterol and other fatty substances in the blood, and an order dated 09/21/10 for lipid panel laboratory monitoring every six months. Further review of Resident #13's medical record revealed no lipid panel laboratory results for September of 2012.</p> <p>An interview with Nurse #2 on 11/08/12 at 12:08 PM revealed the Physician's order dated 09/21/10 for lipid panel laboratory monitoring was an active order to be completed in the months of March and September based on past monitoring. Nurse #2 stated order slips for laboratory tests were given to the nursing secretary who transcribed the order to a calendar for the month and day the blood was to be drawn.</p>	F 281	<p>To correct the deficiency of the facility failing to obtain a physician ordered laboratory test the following correction plan was put in place</p> <p>A 100% lab audit was completed for all residents with lab orders</p> <p>Review of lab order process and follow-up was conducted with all Nurses and Nursing Secretary on 11/14/2012 &amp; 12/6/2012</p> <p>A 100% lab audit will be completed by the Nursing Secretary and Staff Development Coordinator on a weekly basis x 4 weeks, then monthly x 3 months and quarterly thereafter.</p> <p>All results will be compiled for review in the quarterly QA/PI Committee Meetings. to determine continued compliance.</p> <p>The Charge Nurses on all shifts is responsible to enter each new lab and chart the date results obtained and disposition of results on the current lab log.</p> <p>The 1<sup>st</sup> Shift Charge Nurse will report to the morning interdisciplinary team compliance with the current lab log. The D.O.N. will then implement a plan for any discrepancies or non-compliance with lab log documentation.</p>	<p>11/29/2012</p> <p>12/6/2012</p> <p>12/6/2012</p> <p>12/6/2012</p> <p>12/6/2012</p>

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F 281	Continued From page 5 During an interview on 11/08/12 at 1:35 PM the nursing secretary reviewed the laboratory calendar for September 2012 and confirmed Resident #13's lipid panel order was not transcribed to a scheduled date for staff awareness. The nursing secretary could not explain how the laboratory order had been omitted from the calendar.	F 281			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  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 observations, record review, and staff interviews the facility failed to secure indwelling urinary catheter tubing to prevent excessive tension and facilitate flow of urine for 1 of 3 residents reviewed for indwelling urinary catheters (Resident #23).  The findings are:	F 315	To correct the cited deficiency for staff failure to secure indwelling urinary catheter tubing to prevent excessive tension and facilitate flow of urine, the following corrective action was taken  Resident #23 had the urinary catheter tubing secured to residents leg  All other residents who have indwelling urinary catheters were reviewed on 11/8/2012 to assure compliance with securing catheter apparatus to leg to prevent catheter tension and facilitate flow of urine.  Education on proper care of urinary-catheters given to all nursing staff.  To monitor performance with compliance, the facility will require all hall nurses to chart daily on the treatment administration record that all residents with indwelling urinary catheter have a securing catheter apparatus to leg to prevent complications due to catheter use.	11/8/2012      11/14/2012 12/6/2012	

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F 315	Continued From page 6  Resident #23 was admitted with diagnoses including benign prostatic hyperplasia (BPH) and urinary retention. An annual Minimum Data Set (MDS) dated 08/02/12 revealed Resident #23 had an indwelling urinary catheter and did not have a urinary tract infection during the last thirty days. The Care Area Assessment Summary for indwelling catheter stated Resident #23 had diagnoses including BPH and urinary retention and had a catheter in place.  A care plan dated 04/02/12 indicated Resident #23 had a indwelling urinary catheter related to urinary retention. The stated goal was for Resident #23 to be free of complications associated with the indwelling urinary catheter through the next review on 11/10/12.  An observation of Resident #23 on 11/07/12 at 10:30 AM revealed his incontinence brief was unfastened and he was turned on his right side so the treatment nurse could apply barrier cream to his buttocks. The indwelling urinary catheter tubing was not secured and was draped over the top of his right above the knee amputation stump and hung off the side of the bed. A subsequent observation during care rounds on 11/08/12 at 11:35 AM revealed nurse aide (NA) #1 unfastened Resident #23's incontinence brief and he was turned on his right side. The indwelling urinary catheter tubing was not secured and was draped over the top of his right above the knee amputation stump and hung off the side of the bed.  During an interview on 11/08/12 at 11:40 AM NA #1 stated Resident #23 usually had a leg strap to	F 315	The Staff Development Coordinator will audit for compliance with proper care of urinary catheters and compile a report weekly with report to the daily morning interdisciplinary team meeting.  The Staff Development Coordinator will continue to audit weekly and prepare a report monthly x 3 months and then quarterly thereafter.  Quarterly reports will be reviewed by the QA/PI Committee to determine continued compliance.	12/6/2012	

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F 315	Continued From page 7 secure the indwelling urinary catheter tubing and she did not know why he did not have one. NA #1 further stated she would let the nurse know Resident #23 needed a leg strap for his urinary catheter tubing.  An interview was conducted with the Director of Nursing (DON) on 11/08/12 at 11:50 AM. The DON stated she expected residents with indwelling urinary catheters to have their catheter tubing secured with a leg strap at all times to prevent injury.	F 315		
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 observations, record review, and staff interviews the facility failed to implement fall interventions for 1 of 3 sampled residents (Resident #61).  The findings are:  Resident #61 was admitted with diagnoses including dementia, vertigo, and degenerative joint disease. The Care Area Assessment Summary for urinary incontinence completed 01/23/12 stated Resident #61 was at high risk for	F 323	To correct the deficiency concerning the facilities failure to implement fall interventions the following action plan was implemented  Resident #61 had fall mats placed on each side of low bed  Wheelchair/bed alarm usage was reviewed with each staff member on each shift for this resident and the Nursing Worksheet was updated by the Care Plan Nurse to include mats to both side of low bed while resident in bed	11/7/2012       11/7/2012



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F 323	<p>Continued From page 8</p> <p>falls due to degenerative joint disease, vertigo, and having had a fall since admission. A quarterly Minimum Data Set (MDS) dated 10/22/12 revealed Resident #61 had short and long-term memory loss and moderately impaired cognitive skills for daily decision making. The quarterly MDS indicated Resident #61 required extensive assistance with transfers, walking, and toilet use. The quarterly MDS also noted Resident #61 had two or more falls since the prior assessment without injury and two or more falls since the prior assessment with minor injuries.</p> <p>Review of the care plan for falls dated 04/11/12 revealed Resident #61 had a potential for falls due to an unsteady gait. Interventions included: low bed with falls mats, pad alarm to wheel chair and bed, monitor for increased agitation, dementia program, and toileting program.</p> <p>Review of Resident #61's fall investigations revealed he had ten unobserved falls from bed since 08/01/12. Three of the falls resulted in abrasions and the remaining seven falls were without injury.</p> <p>An observation of Resident #61 on 11/06/12 at 4:00 PM revealed he was resting in a low bed with 1/4 side rails on both sides of his bed. A pad alarm was noted on the seat of his wheel chair. There was no pad alarm on the bed or fall mat(s) observed by the bed or anywhere in the room. During a subsequent observation on 11/07/12 at 10:45 AM Resident #61 was observed resting in a low bed with 1/4 side rails on both sides of his bed. A pad alarm was noted on the seat of his wheel chair. There was no pad alarm on the bed or fall mat(s) observed by the bed or anywhere in the</p>	F 323	<p>One-on-one supervision of resident implemented while resident is in wheelchair with tab alarms removed.</p> <p>Mandatory education given related to usage of fall mats with each resident that requires a low bed and proper usage of wheelchair pad alarms and bed alarms reviewed.</p> <p>Review of Nursing Worksheet completed which included the process of recognition of discrepancies with plan of care and actual care delivery. Discrepancies in plan of care and worksheet information will be reported immediately to care plan nurse for correction.</p> <p>To prevent discrepancies of Nursing Worksheet information to care delivery, the Charge Nurse will complete an audit daily x 7 days to match actual delivery to plan of care. Charge Nurse will then audit and document findings weekly x 4 weeks, then monthly until substantial compliance is reached.</p> <p>All falls reviewed daily in morning interdisciplinary meetings with interventions implemented and added to plan of care and nursing worksheets.</p> <p>Falls committee to review changes to plan of care by reviewing falls on a weekly basis x 4 weeks, then will meet monthly x 3 months to determine continued compliance.</p>	<p>1/28/2012</p> <p>1/14/2012 1/26/2012</p> <p>1/26/2012</p> <p>1/26/2012</p> <p>1/26/2012</p> <p>1/26/2012</p>	

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NAME OF PROVIDER OR SUPPLIER  CAMELOT MANOR NURSING CARE FAC			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 9 room.</p> <p>Review of a nurse aide (NA) care plan report dated 11/07/12 revealed low bed, toileting program, and dementia program were listed for Resident #61. The fall mat(s) and pad alarm to the bed were not included on the NA care plan report.</p> <p>During an interview on 11/07/12 at 1:50 PM the Director of Nursing (DON) reviewed Resident #61's care plan and stated the current interventions to prevent injuries for falls from bed included low bed, fall mat(s) and a pad alarm on the bed. The DON also reviewed the NA care plan report and stated the NA care plan report should have been updated to include the use of fall mat(s) and a pad alarm on Resident #61's bed. The DON further explained the NA care plan reports were printed daily and used to communicate residents care needs to the NAs and included fall interventions.</p> <p>An interview with the MDS Coordinator on 11/07/12 at 2:25 PM revealed the NA care plan reports were printed off daily by the charge nurse for use by the NAs. The MDS Coordinator stated she typically updated the NA care plan report as soon as any changes were agreed upon and could not explain why the fall mat(s) and pad alarm to bed were not added to Resident #61's information on the NA care plan report.</p> <p>On 11/07/12 at 3:05 PM the DON observed Resident #61 awake in his low bed with ¼ side rails on both sides of the bed. The DON confirmed there were no fall mat(s) in the room and noted the pad alarm on the seat of Resident</p>	F 323	Report will be reviewed by the QA/PI Committee on a quarterly basis to determine continued compliance.	

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

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F 323	Continued From page 10 #61's wheel chair was a bed alarm and could be used on the seat of a wheel chair as well. The interview further revealed the facility did not always have an adequate supply of pad alarms and as a result the pad alarm had to be transferred to the resident's bed or chair with the resident.	F 323			