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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 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, record review, resident interview, and staff interviews the facility failed to ensure a resident's privacy with a surveyor for 1 of 1 residents reviewed for privacy and confidentiality (Resident #10).	F 164	For resident #10 that was affected by this alleged deficient practice, a corrective plan has been put in place. Resident #10 was visited by the Director of Nursing on 8-19-2014 and was interviewed to see if the resident had any issues related to	8/29/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/22/2014

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 164	Continued From page 1 The findings included: Resident #10 was admitted to the facility on 09/20/10 with diagnoses which included hemiplegia, seizure disorder, and anxiety disorder. The Quarterly Minimum Data Set (MDS) dated 06/24/14 indicated Resident #10 was cognitively intact for daily decision making, capable of making his needs known, and required extensive assistance with his activities of daily living (ADL). On 07/29/14 at 4:44 PM an interview was conducted with Resident #10. He stated an office employee with the facility came into his room asking him what he had told the surveyor that had asked him questions. He further stated he told the facility employee he had answered the surveyor's questions and had gotten some things off of his chest. On 07/29/14 at 5:44 PM Resident #10 was observed laying in his bed and an office employee coming out of the resident's room. Resident #10 identified the employee as the Administrative Assistant (AA). Resident #10 stated the AA had come into his room earlier that morning asking him what he and the surveyor had discussed. Resident #10 further stated the AA told him "not to say anything bad about the facility." Resident #10 indicated the AA repeatedly came in and out of his room bugging him. On 07/30/14 at 2:48 PM the AA was observed leaving Resident #10's room. Resident #10 stated the AA had not been into his room as often as he had the day before but had repeatedly asked him questions about what he and the surveyor had discussed. He further stated he had informed the	F 164	being able to have private conversations. Resident stated he did not. Informed resident if he had any issues, to contact the Director of Nursing or the Social Worker. Social worker will be responsible for reminding resident of his right to privacy. Residents with the potential to be affected by this alleged deficiency will be informed of their rights to private conversations at the next resident council meeting held on August 27th,2014 and during staff/resident interactions. Continued Education through Inservice training for nursing and administrative staff at least x 2 yearly and/or as needed by the Staff Development Coordinator. Inservice was conducted on 8-13-2014 on Privacy policies and procedures including allowing for private conversations for Nursing and Administrative Staff by the Staff Development Coordinator. Continuing interactions with families and residents, identifying any areas of concern related to Privacy during scheduled careplan meetings by the MDS Coordinator. Director of Nursing or Designee, will follow-up on any issues related to Privacy during Monthly Resident Council Meetings. Monitoring Corrective Actions to ensure	

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 164	Continued From page 2 AA that what he and the surveyor had discussed was private. On 07/31/14 at 11:25 AM an interview was conducted with the Administrative Assistant (AA). He stated he could not recall asking Resident #10 any questions. He further stated the staff was expected to maintain a resident's privacy. On 08/01/14 at 3:24 PM an interview was conducted with the Social Worker. She stated the staff was expected to uphold a resident's privacy. On 08/01/14 at 3:55 PM an interview was conducted with the Administrator. She stated she expected the staff to ensure a resident's privacy.	F 164	no reoccurance of deficient practice: Observing staff interactions with residents/family, noting if privacy is being interferred with during their interactions. Observations to be conducted during daily rounds. Ongoing monitoring by the Hall Nurses/Administrative Nurses. Grievances and complaints reviewed by the Director of nursing and/or social worker to identify areas of invasions of privacy daily x 2 weeks, twice weekly x 2 weeks, monthly x 2, then reviews at monthly and quarterly QAPI Meetings. Continued inservice education performed by staff development coordinator, to inform staff of Privacy Policies x 2 yearly and PRN	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	F 225		8/29/14

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 225	Continued From page 3 including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to submit the 24 Hour Initial Report to the Health Care Personal Registry (HCPR) for 1 of 5 residents identified with abuse/neglect allegations. (Resident #18) The findings included: Resident #18 was readmitted to the facility 07/08/11 with diagnoses which included muscle weakness, peripheral vascular disease, depression, and bipolar disorder. A quarterly Minimum Data Set (MDS) dated 06/10/14 indicated the resident's cognition was severely impaired. The MDS specified Resident #18	F 225	For this alleged deficiency for Resident #18, Camelot Manor Nursing Facility Inc., has updated and implemented its Abuse and Neglect policy to reflect exactly the requirements established by CMS. All allegations of abuse or Neglect will be reported to the Healthcare Personnel Registry within 24 hrs and a 5 day follow-up report per policy. No adverse Long-Term effects regarding this alleged incident has been noted. Director of Nursing or Designee/ Compliance Officer. Any resident having the potential to be affected by this alledged deficient	

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 225	Continued From page 4 required extensive staff assistance with toileting, transfers, and dressing. A review of a grievance report dated 06/26/14 was conducted. The report contained documentation of an incident that occurred 06/26/14. The allegation was made by Resident #18 concerning Nurse Aide (NA) #4. The allegation specified NA #4 refused to provide a clean brief, fought with the resident over the call light, and elbowed the resident in the chest twice. The report did not contain a copy of a 24 hour initial report to the HCPR. An interview was conducted with the DON on 07/30/14 at 3:19 PM. The DON stated she initiated an investigation as soon as she was informed of this incident. She added based on her interviews with the resident and staff, she did not think this incident really happened so she did not report this incident to the state agency. In a continued interview on 07/31/14 at 5:13 PM, the DON stated she thought if she saw no abuse within 24 hours of investigation, she did not have to make a 24 hour report to the HCPR.	F 225	practice, Camelot Manor Nursing and Rehab Facility has updated and implemented its abuse and neglect policy to exactly reflect the reqjuirements established by CMS. All allegations of abuse and neglect will be reported to the Health Care Registry swithin 24 hours and a 5 day follow-up complete report. Director of Nursing or Designee/Compliance Officer. Systemic change to prevent reoccurrance: - Updated current policy of Abuse and Neglect to reflect CMS requirements. Compliance Officer. - Inservice held for Nursing and Administrative Staff on 8-13-2014 on ndew policies for abuse and neglect. Director of Nursing/Compliance Officer. - Inservice to be held for all staff on reporting Abuse and Neglect at least 2 x yearly. Staff Development Coordinator. - Review monthly Resident Council Grievances for areas of possible abuse monthly. Director of Nursing/Social Worker Monitoring action to ensure no reoccurance: - Observe for any signs of abuse or Neglect during daily rounds. Assigned Hall Nurse/Administrative Nurses/Director of Nursing, with reporting to Director of Nursing immediately - ongoing.	

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 225	Continued From page 5	F 225	- Continuing education to review policies and procedure to prevent abuse and neglect and to inform staff to report any Abuse or Neglect to Director of Nursing immediately. Staff Development Coordintor. Review all grievances and complaints for abuse and neglect allegation daily x 2 weeks, twice weekly x 2 weeks then monthly x 2. Review any issues that arise to monthly and quarterly QAPI Committee. Grievances would be addressed immediately if allegations of abuse identified. Director of Nursing/Social Worker	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and policy review, the facility failed to protect residents and follow the abuse/neglect policy relating to investigation for 1 of 5 residents identified for allegations of abuse/neglect. (Resident #18). The findings included: A review of facility guidelines/policy and	F 226	For resident #18 that was affected by this alleged deficient practice, a corrective plan has been put in place. Camelot Manor Nursing Facility Inc., has updated and implemented its abuse and neglect policy to exactly reflect the requirements established by CMS. Allegation of Abuse and Neglect will be investigated as directed in policy and all interviews with staff will be written down as part of the	8/29/14

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 226	Continued From page 6 procedures relating to abuse and neglect was conducted. The policy was reviewed/revised 2014. The policy contained in part the following: If a staff member was suspected of abuse/neglect, the staff member would be suspended from all responsibilities and duties while the investigation was in progress. The Director of Nursing (DON) will finalize the written investigation by speaking to all persons known to be present and in contact with the resident 24 hours prior to findings. These statements will include names, times in contact, description of the resident's mood, mental, physical status, mobility status, conversations and other pertinent information pertaining to the findings. Resident #18 was readmitted 07/08/11 with diagnoses which included muscle weakness, peripheral vascular disease, depression, dementia, and bipolar disorder. A quarterly Minimum Data Set (MDS) dated 06/10/14 indicated the resident's cognition was severely impaired. The MDS assessments specified Resident #18 required extensive staff assistance with toileting, transfers, and dressing. A review of a grievance report dated 06/26/14 was conducted. The report contained documentation of an incident that occurred 06/26/14. The allegation was made by Resident #18 concerning Nurse Aide (NA) #4. The allegation specified NA #4 refused to provide a clean brief, fought with the resident over the call light, and elbowed the resident in the chest twice. Documented under the heading "Action taken and results" was the statement that the incident was investigated and people involved interviewed and their statements attached. The report was signed by the DON and dated 06/27/14. Resident	F 226	investigation. Staff that are accused in the allegation will be suspended until investigation is complete and termination or reinstatement will be determined by Director of Nursing, Administrator and/ or designee/Compliance Officer. For any resident with the potential to be affected by this alleged deficient practice, a corrective action plan has been put in place. Camelot Manor Nursing Facility Inc., has updated and implemented its abuse and neglect policies to exactly reflect the requirements established by the CMS. Allegations will be investigated as directed in policy and all interviews with staff will be written down as part of the investigation and reviewed by Director of Nursing and/or administrator and/or designee/Compliance Officer. Updated current abuse and neglect policies on August 13, 2014 to reflect CMS requirements to prevent further occurrence was reviewed by Compliance Officer/Director of Nursing and Administrator. Inservice conducted on August 13, 2014 by Staff development Coordinator for nurses and Administrative Staff on updated Abuse and Neglect Policy. Inservice for all staff to go over Abuse and Neglect Policies was conducted by Staff Development Coordinator on 8-28-2014	

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 226	Continued From page 7 #18 had also been interviewed. Statements from Nurse #2, NA #3, NA #4, and NA #5 were attached to the report. There were no statements written by the DON regarding interviews that were conducted with this staff. There was no documentation to reflect NA #4 had been suspended during the investigation. Review of staff assignment sheets revealed NA #4 did work in the facility 06/27/14, but not on Resident #18's hall. An interview was conducted with the DON on 07/30/14 at 3:19 PM. The DON stated she did not think this incident happened. She explained over the years, Resident #18 had complained about other nurse aides. Those complaints were found to be unsubstantiated. She added after investigating the incident, she did not think abuse occurred. The DON stated if she had thought it was abuse, NA #4 would have been suspended during the investigation. The DON stated she did not interview other alert and oriented residents near Resident #18's room. In a continued interview on 07/31/14 at 5:13 PM, the DON stated she did speak with involved staff members but did not actually document her interviews with them. The DON stated she conducted the investigation in a timely manner but did not follow the facility protocol for investigation abuse/neglect.	F 226	Resident Grievances will be monitored by DON and Social worker for any complaints of abuse or neglect daily x 2 weeks, twice x 2 weeks, then monthly x 2. Audits will be reviewed by QA Committee at monthly and quarterly QAPI meetings. Monitoring corrective actions to ensure no reoccurances will be met by observing for any signs of abuse or neglect during hall rounds by hall nurses and Administrative nurses. Will Audit daily x 2 weeks, twice weekly x 2 weeks, then monthly x 2. Director of Nursing will review audits for any abuse or suspicion of abuse. Will review results at monthly and quarterly QAPI meetings by the QA committee. Continuing education through inservices to review policies and procedures on abuse and neglect x2 yearly and as needed. All new hires will be trained on abuse and neglect policies during orientation by the Staff Development Coordinator. DON and/or Social Worker and/or Administrator will review Audits of all Grievances and complaints for allegations of abuse and neglect daily x 2 weeks, twice weekly x 2 weeks and monthly x 2. Review any issues at monthly and quarterly QAPI meetings.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or	F 241		8/29/14

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 241	Continued From page 8 enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to maintain a resident's dignity by taking him into the dining room with soiled clothing for 1 of 6 residents reviewed for dignity and respect (Resident #86). The findings included: Resident #86 was admitted to the facility on 02/08/14 with diagnoses which included coronary artery disease, muscle weakness, and kidney disease. The Quarterly Minimum Data Set (MDS) dated 05/16/14 indicated his cognition was moderately impaired but was capable of making his needs known, required extensive assistance with his activities of daily living (ADL), and was frequently incontinent of bowel and bladder. Resident #86 was observed on 07/29/14 at 5:10 PM sitting in his wheelchair in his room, dozing off and on, and a strong odor of urine was observed in his room. Further observation revealed Resident #86's pants were soaked with urine and a puddle of urine on the floor under his wheelchair. Continued observations revealed Nurse Aide (NA) #8 came into Resident #86's room and told him "it is time for supper." She was observed to push him into the hallway, without stepping in the puddle of urine, and stated to NA #9 "could you take him on to the dining room for supper." NA #9 was observed to push Resident #86 to the dining room, push him up to a table, bend over and lock his wheelchair.	F 241	For resident #86 affected by theis deficient practice, resident was taken to hall bathroom and changed. Resident was washed, with clean clothing, placed on him at tha time. Staff on resident hall, all shifts were instructed to check him every two hours to make sure resident was clean and dry. Resident on Lasix so they were instructed to change more frequently as needed. Staff involved were disciplined. Administrative Nurse/Hall Nurses/Director of Nursing or designee. For other residents that have the potential to be affected by this deficient practice, hall rounds are conducted daily. Residents that are incontinent are checked for dryness. Staff are observed also to ascertain if they are giving inontinent care and toileting as needed. Administrative Nurses/Hall Nurses/Director of Nursing or designee. Corrective action: - Reassessments of residents if change in continence status, Charge Nurse refers to MDS. - Toileting Program with Restorative as indicated. MDS Coordinator. - Updating Careplans and worksheets as indicated. MDS Coordinator/Restorative Nurse.	

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 241	Continued From page 9 Dining room staff was observed on 07/29/14 at 5:16 PM to set-up Resident #86's meal tray. He was observed sitting at the table eating his dinner with another resident. An interview was conducted on 07/29/14 at 5:20 PM with NA #9. She stated she had not observed Resident #86's pants to be wet. She further stated when she bent over to lock his wheelchair she did not smell an odor of urine on Resident #86. An interview was conducted on 07/29/14 at 5:24 PM with NA #8. She indicated she was not the NA assigned to Resident #86 and she was unaware that his pants were wet with urine. She further indicated she had not seen the puddle of urine under the resident's wheelchair when she was in his room. She stated she had been sick and was unable to smell the odor of urine on Resident #86 or the odor of urine in his room. She further stated the NA assigned to Resident #86 was on her dinner break and the NA's were expected to check residents every 2 hours and more often if needed. She revealed she had not checked Resident #86 prior to taking him out of his room to dinner. On 07/29/14 at 5:26 PM, the second shift charge nurse was informed of the observations of Resident #86. The charge nurse was escorted to Resident #86's room and he confirmed the puddle of urine on Resident #86's room floor. He immediately went to the dining room and was observed; in a low toned voice, to ask Resident #86 "are you wet and uncomfortable?" Resident #86 replied "yes, I cannot get any help." The charge nurse was observed to interrupt Resident	F 241	Monitoring corrective action to ensure effectiveness: -Hall round sheet used by Hall Nurse to monitor each incontinent resident before meals to assure they are clean, dry and odor free, daily x 2 weeks, twice week x 2. Monthly x 2. Review results at monthly and quarterly QAPI meetings. Hall Nurse/Director of Nursing or designee. - Administrative rounds to identify any areas of deficiency and correct, educate or discipline as indicated. Daily x 2 weeks, twie weekly x 2, monthly x2. Administrative Nurses, Director of Nursing or designee. Review audits monthly and quarterly at QAPI Committee. Compliance Officer. - Continued education through inservices on ADL care (Incontinent Care) 2 x yearly and as needed. All new hires, Certified Nursing Assistants and Nurses will be instructed in incontinent care of a resident. Staff Development.	

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 241	Continued From page 10	F 241		

#86's meal, take him out of the dining room, into the hallway bathroom, and was observed to ask NA #8, NA #10, and NA #11 to assist Resident #86 with a change of his clothing.

On 07/29/14 at 5:38 PM, the 3 NA's were observed to assist Resident #86 to a standing position from his wheelchair. NA #11 was observed to remove the resident's wet pants, his wet socks, and the soaked brief; which she was observed to use 2 hands to dispose of the heavy brief into the garbage can. NA #10 was observed to wipe and clean the urine off of Resident #86's wheelchair cushion. NA #8 and NA #11 were observed to wash and clean Resident #86, apply a dry clean brief, place dry pants back on Resident #86, and change his socks. During the observations Resident #86 stated to the NA's " I am worn out and I can't get no one to help me." NA #11 was observed to push Resident #86 back to the dining room and reheat his dinner meal.

An interview was conducted on 07/30/14 at 9:07 AM with Resident #86. He stated his brief was changed on 07/29/14 before he went to "bingo" at 2:00 PM. He further stated "it is so aggravating and it happens so often that I have gotten used to being wet and it doesn't embarrass me anymore."

An interview was conducted on 07/30/14 at 10:38 AM with the Director of Nursing (DON). She stated she expected the NA's to change a resident every 2 hours or more often if needed. She further stated she would have expected the NA's to change Resident #86 before he was taken to the dining room.

An interview was conducted on 07/31/14 at 3:39 PM with NA #12. She stated she was assigned to

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 241	Continued From page 11 Resident #86 on 07/29/14. She indicated she had checked on Resident #86 at 3:00 PM and did not suspect that he was wet. She further indicated she had not checked him anymore before she gave NA #8 a report of her assigned residents and left the hall for her dinner break. She stated she should have changed the resident before she left the hall. She further stated she had made a mistake because she was ultimately responsible for his care.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES 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. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, staff and resident interviews, the facility failed to honor a resident's selection of time for getting up in the mornings for 1 of 3 residents reviewed for choices (Resident #86). The findings included: Resident #86 was admitted to the facility on 02/08/14 with diagnoses which included coronary artery disease, muscle weakness, difficulty walking, dementia, and kidney disease. The Admission Minimum Data Set (MDS) dated	F 242	Resident #86, who was allegedly affected by this deficient practice, was interviewed by Director of Nursing and it was determined that he wanted to sleep later but that he still wished to go to the dining room for breakfast at around 7:30 a.m. Resident was taken off the get-up list for third shift and now does not get up until 1st shift comes in. For any other resident that might be affected by this alleged deficient practice, all residents that have been deemed alert and oriented, per their last MDS	8/29/14

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 242	Continued From page 12 02/15/14 indicated his cognition was moderately impaired, non-ambulatory, but was capable of making his needs known and not having rejected care. Further review of the MDS revealed Resident #86 was coded as having the choice of his awake and sleep times as very important to him. The MDS indicated Resident #86 needed extensive assistance with 2 person physical assist for bed mobility and transfer. An interview was conducted on 07/29/14 at 10:21 AM with Resident #86. He stated he wanted to sleep at least until 8:00 AM. He indicated the Nursing Assistants (NAs) would get him up between 5:30 and 6:00 AM every morning and that even if he told them he wanted to sleep later they would get him up. An observation on 07/30/14 at 5:38 AM of Resident #86 revealed he was out of bed, in his room, and sitting in his wheelchair with his eyes closed. An interview was conducted on 07/30/14 at 5:50 AM with NA #15. She verified she was the NA that got Resident #86 out of bed. She stated he had not indicated to her he wanted to sleep in but she had not asked him if he wanted to get up. She further stated she was unaware that Resident #86 wanted to sleep in until at least 8:00 AM. An interview was conducted on 07/30/14 at 6:10 AM with NA #16. She indicated she assisted NA #15 with getting Resident #86 out of bed but was unable to recall if he had requested to sleep in. She further indicated she was unaware that Resident #86 wanted to sleep in until at least 8:00 AM. She stated the NA's were expected to get the residents out of bed before first shift staff came in	F 242	Assessment, will be reassessed for their preferred get-up time. This will then be indicated on their careplans and on daily care sheets. The daily care sheets will be given to the Certified Nursing Assistant by the hall nurse daily. This is the responsibility of MDS coordinator and/or Restorative nurse and the Hall nurse. Systemic Changes to Prevent reoccurrances: - Updates and changes to careplans, quarterly and yearly with MDS Assessment per resident requests are conducted by the MDS Coordinator/Restorative Nurse. When resident states to staff at any time, they have a change in preferences, report is given to MDS Coordinator or Restorative Nurse for Update on Care plan. It is the responsibility of the MDS Coordinator/Restorative Nurse to update preferences. Inservice on 8-28-2014 to Re-educate Staff on Resident Preferences and to report any Resident request for change in preferences to MDS Coordinator or Restorative Nurse. Inservice conducted by Staff Development Coordinator. Current updating to care plans on all alert and oriented residents per last MDS Assessment for preferences in get-up time will be the responsibility of the MDS Coordinator. Monitoring corrective actions are ongoing	

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 242	Continued From page 13 unless a resident's name was on the "do not" get up list. NA #16 verified Resident #86's name was not on the list. An interview was conducted on 07/30/14 at 10:15 AM with NA #4. She stated she was unaware Resident #86 wanted to sleep in until 8:00 AM. She further stated the NA's were instructed to get the residents up for all of their meals unless the resident refuses to get up. She indicated she has not asked the residents that she was responsible for getting up in the mornings if they wanted to sleep in or not. She further indicated if a resident chooses to get up later then the time would be specified on the NA's resident care guide. She verified Resident #86's name nor was the time indicated on her resident care guide. An interview was conducted on 08/01/14 at 11:34 AM with the Activity Director. She revealed she completed the assessments in the MDS preferences section. She stated she checked the boxes that apply to the questions of whether it is important, very important, or not important to choose what time to get up in the morning. She verified Resident #86's preference for getting up in the morning was between 8:00 and 9:00 AM. She further verified she had not shared the information regarding Resident #86's time preference for getting up in the mornings with any nursing staff. An interview was conducted on 08/01/14 at 11:42 AM with Nurse #3. She verified on the nurses care guide there was not a particular time listed for Resident #86 to get up. She stated all the residents were supposed to be gotten up before every meal and taken to the dining room that they were assigned to for their meals. She further	F 242	with daily interactions with residents and families. If change in Preferences is voiced or noted, MDS Coordinator will be informed. This is the responsibility of the Director of Nursing/Social Worker. Review Resident Council Minutes for issues monthly. If there are changes in preferences, the DON and/or designee will inform MDS Coordinator for care plan changes monthly. MDS Coordinator will discuss changes at monthly QA. This is the responsibility of the Director of Nursing, MDS Coordinator and/or designee. Ongoing Inservice Education to re-educate staff on resident preferences will be conducted by the Staff Development Coordinator and/or designee. New hires will also be educated on preferences, and who to inform if resident expresses a desired change in Preference. These will be conducted during orientation for new hires and 2x yearly and/or as needed for nursing staff. Monitoring Corrective Action: Audits on all current residents preferences for getting-up time has been conducted by MDS Coordinator and Restorative Nurse. Daily C.N.A. Care Plans have been updated as indicated per audit. Ongoing audits conducted by reviewing Grievance Reports and Complaints will be done daily x 2 weeks, twice weekly x 2	

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 242	Continued From page 14 stated she was unaware of Resident #86's choice of 8:00 AM for getting out of bed. An interview was conducted on 08/01/14 at 12:23 PM with the Director of Nursing (DON). She revealed the time preferences that a resident wanted to get up in the mornings was completed by the activity director. She stated her expectation was to arrange the resident's preferences according to their wishes to the best of their ability.	F 242	and then monthly. Changes will also be made, if identified during quarterly and yearly MDS Assessments. Audits will be reviewed with any issues addressed at monthly and quarterly QAPI Meetings. Responsibility of MDS Coordinator/Restorative Nurses/Director of Nursing.	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews the facility failed to provide an individualized activity program for 1 of 5 sampled cognitively impaired residents (Resident #40). The findings included: Resident #40 was admitted to the facility on 01/19/11 with diagnoses which included difficulty walking, generalized muscle weakness, dementia, anxiety state, generalized pain, debility, and Alzheimer's. The annual Minimum Data Set (MDS) dated 01/13/14 coded Resident #40 as severely	F 248	Resident #40 affected by alleged deficient practice, a new comprehensive Activity Assessment was done to identify the interests, activities of this resident. This was done with consideration of mental and physical fucntion per last MDS Assessment. Care plan has been updated as indicated by new Assessment. This was done by the Activity Director/Assistant Activity Director. For residents having the potential to be affected by this alleged deficiency, there will be new activity assessments completed on all residents with interests	8/29/14

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 248	Continued From page 15	F 248		

impaired cognitively for daily decision making skills but she was able to make herself understood and understands others. The MDS coded Resident #40 as nonambulatory and dependent on staff for extensive assistance for all activities of daily living (ADL) including planning and transporting Resident #40 to activities of her interest. The MDS indicated Resident #40 preferred and considered it very important to have books, magazines and newspapers available, to participate in religious activities and go outside in good weather. The MDS further indicated she considered it somewhat important to listen to music, keep up with the news and do favorite activities.

Review of the current care plan revised 07/14/14 identified Resident #40 for no participation in structured activities with a goal of in room visits for socialization and to attend activities of interest. The interventions developed for Resident #40 included escort the resident to and from activities of interest, provide in room visits for reality orientation, provide time in the sensory room and one on one sensory programs to encourage relaxation, exploration, communication, and enjoyment, and provide sensory stimulation and enhance quality of life.

Review of the activity attendance log from January 2014 through July 2014 revealed the number of days of attendance in the 7 months as follows:

a. In room visit with sensory response 0
b. Arts and crafts 1
c. Religious/Spiritual 8
d. Games 8
e. Movies 3

and desired activities identified with consideration of mental and physical function per last MDS assessment. Care plans will be updated to reflect any changes in desired activities by the Activity Director/Assistant Activity Director.

Corrective actions for systemic changes:

Resident Council input to initiate new activities or activities of interest. This is the responsibility of Activity Director.

Quarterly and yearly assessments completed as scheduled with care plans updated by the Activity Director.

Random interview with residents and family to discover new or different interests will be conducted by the Activity Director.

Inservice for Nursing Staff conducted by the Staff Development Coordinator on August 28th,2014 to inform the importance of resident activity participation and the need for them to assist residents to activities and also provide activities in rooms, such as radio, TV, etc. This will be the ongoing responsibility of the Activity Director

Monitoring corrective actions to ensure effectiveness:

Audits of scheduled MDS Assessments to ascertain activity Assessment and Care plans are done and updated as scheduled and in a timely mannner 1x weekly x 1

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 248	Continued From page 16 f. Outside activity 2 g. Out of the facility activity 0 h. Gardening 0 i. Sensory Room 0 j. Dementia Program 0 During these 7 months, there was no documentation to support Resident #40 ever attending any gardening or outdoor activity, sensory room, or dementia program. Review of the quarterly activity departmental notes dated 01/10/14, 04/14/14, and 07/14/14 indicated Resident #40 was able to voice her needs and wants to the staff. The notes further revealed activity staff continued to provide in room visits to deliver mail, offer reading materials, and encourage activities of interest. There were no notes of offers with refusals to attend activities of her preference. On 07/28/14 at 11:55 AM Resident # 40 was observed in her wheelchair in her room watching TV. Magazines were observed on the bottom shelf of the bedside table on the other side of the bed not in the resident's reach. On 07/29/14 at 3:15 PM Resident #40 was observed in bed with the covers on with her eyes closed resting. Magazines were observed on the bottom shelf of the bedside table on the other side of the bed not in the resident's reach. On 07/30/14 at 12:55 PM Resident #40 was observed having lunch with other residents outside under the picnic pavilion. There was no music playing at this time. On 07/31/14 at 5:53 PM Resident #40 was observed sitting in her wheelchair in her room	F 248	month, then monthly x 2 months. Will be reviewed at monthly and quarterly QAPI meetings to ensure compliance with interventions as indicated. These audits are the responsibility of the Compliance Officer. Audits of Attendance Sheet for activities will occur to assure residents that desire to attend in-house or planned out-of-facility are attending. Weekly x 2 weeks, then monthly x 2 months. This is responsibility of the Compliance Officer. During ongoing scheduled Administrative and Hall Nurse rounds, they will observe staff to make sure they are helping take residents to scheduled activities, ongoing and intervene as necessary. This is the responsibility of the Administrative Nurses/Hall Nurses/Director of Nursing.	

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 248	Continued From page 17 looking at her hands in her lap. The TV was not on and the magazines were observed on the bottom shelf of the bedside table on the other side of the bed not in the resident's reach. On 07/30/14 at 3:20 PM the Activity Director (AD) was interviewed. The AD stated that she gathered information relating to residents' interests past and current from family members when a resident was cognitively impaired. The AD described Resident #40 as alert, attentive, with some confusion but was able to make her needs and wants known. The AD explained that the sensory room and dementia program activities were no longer used due to facility construction. The AD stated Resident #40 received music today during lunch but did not attend today's 2 PM balloon volley activity. The AD further stated that during dining it was considered and checked off on the activity attendance sheet as social time, taster's choice, and music activity. The AD further explained that the radio used during dining was missing, she did not know how long the radio was not available for dining activity, and she would provide a new one. The AD revealed she does not normally do a daily activity note on residents but does complete a quarterly activity note.	F 248		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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.	F 309		8/29/14

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 309	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observations, family, resident and staff interviews and record review the facility failed to assess a resident for constipation for 1 of 1 resident complaining of constipation (Resident #87). The findings included: Resident #87 was admitted to the facility on 07/16/13 with diagnoses that included history of colon cancer, hypertension, delusional disorder, depression, dementia and others. The most recent Minimum Data Set (MDS) dated 04/25/14 specified the resident's cognition was intact. The MDS also specified the resident was always continent of bowel and bladder and did not have constipation. Resident #87 required limited assistance with activities of daily living (ADL) but did not require assistance with eating. Review of Resident #87's physician ordered medications revealed she was not ordered routine or as needed medication for constipation. Resident #87 was ordered by the physician to receive calcium, high blood pressure medication, depression medications and anti-anxiety medication. On 07/29/14 at 3:00 PM a telephone interview was conducted with Resident #87's family. The family member explained that Resident #87 had a history of colon cancer and at times had difficulty with bowel regularity. The family member stated they visited Resident #87 on 07/28/14 and the resident complained of constipation. Resident #87 told the family that she had a partial bowel	F 309	Resident #87, who was allegedly affected by deficient practice. Hall Nurse did not assess nor address resident's medical needs that evening. Charge nurse notified by DFS the next day,Charge Nurse immediately assessed resident. Resident was given a PRN Laxative per standing orders. The medical record revealed the resident had a large BM. Hall nurse was reprimanded and re-educated on immediately addressing resident needs or family request by the Director of Nursing. Any resident with the potential to be affected by this alleged deficient practice will have their needs or family requests addressed immediately by the nurse with appropriate action occuring. Any PRN standing order that is needed will be written on standing order PRN log for Charge Nurse to assess. Log Audits will be the responsibility of the Director of Nursing and/or designee. Systemic changes to ensure that the deficient practice does not reoccur: - Standing order PRN log for Charge Nurse/Hall Nurse. Director of Nursing and/or designee are responsible. - Review of resident reports to assess needs is the responsibility of the Charge Nurse/Hall Nurses. Perform inservices for nurses on importance of meeting resident needs	

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 309	Continued From page 19 movement on 07/26/14 but felt constipated and complained of pain in her stomach. The family member explained that Resident #87 was very private and did not feel comfortable telling the nurse she was constipated. The family member notified Nurse #1 on 07/28/14 at 5:00 PM of the resident's complaint of constipation and asked the nurse to check the resident and felt the resident needed a suppository. On 07/29/14 at 3:20 PM Resident #87 was interviewed and reported that she needed to have a bowel movement but couldn't. Resident #87 stated she was upset because she had repeatedly taken herself to the bathroom but could not have a bowel movement. She also stated that she was having occasional pain in her stomach and pointed to her lower right quadrant. On 07/29/14 at 3:30 PM nurse aide (NA) #2 was interviewed and reported that Resident #87 took herself to the bathroom. She stated she thought the resident had regular bowel movements and was unaware of any concerns with constipation. The NA explained that she asked Resident #87 each day if she had a bowel movement and documented results in the computer. On 07/29/14 at 3:45 PM Nurse #1 was interviewed. She reported that Resident #87's family notified her on 07/28/14 that the resident was complaining of constipation and that they wanted the resident to have a suppository. Nurse #1 explained that she reviewed Resident #87's bowel elimination record and saw the resident had a bowel movement on 07/26/14 and felt no suppository was needed. Nurse #1 stated that since the resident had not gone 3 days without a bowel movement she did not feel the resident	F 309	promptly was completed on 8-13-2014. this was conducted by the Staff Development Coordinator. Review minutes of Resident Council Meeting for care issues, monthly by the Director of Nursing. Monitoring corrective actions to ensure effectiveness: Audit standing order PRN Log daily x 2 weeks, twice weekly x 2, monthly x 2 by the DON and/or designee. Monthly and quarterly QAPI reviews by QA committee until no problems identified. Audit BM reports every 3 days and PRN - ongoing x 1 month if no problems conducted by Director of Nursing and/or designee. Audit weights weekly ongoing by the Director of Nursing and/or designee. Audit skin assessment every month - ongoing by the Director of Nursing and/or designee Continuing inservices on ADL Care services 2 x yearly and PRN conducted by the Staff Development Coordinator.	

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 309	Continued From page 20	F 309		

was constipated and did not proceed with administering medication or assessing the resident for constipation.

On 07/29/14 at 3:50 PM Nurse #1 went to assess Resident #87. The Resident reported to the nurse that she needed to have a bowel movement but couldn't. Nurse #1 assisted the resident into the bathroom but the resident was unable to have a bowel movement. Nurse #1 asked the resident if she was in pain and the Resident said that her stomach sometimes hurt. Nurse #1 felt of Resident #87's abdomen and reported that it was not distended. Nurse #1 left the room and notified the 2nd shift Charge Nurse of Resident #87's complaint.

A nurses' note made by the 2nd shift Charge nurse dated 07/29/14 at 4:31 PM specified Nurse #1 implemented the facility's standing orders and administered Milk of Magnesia (a laxative) to Resident #87.

On 07/29/14 at 4:40 PM the 2nd shift Charge Nurse was interviewed and reported that the facility had a bowel protocol. He reported that the protocol was to give residents Milk of Magnesia (a laxative) if they had gone 3 days without a bowel movement, and if no results in 8 hours then administer a suppository and wait for results. The 2nd shift Charge nurse added that at any time a resident complained of constipation the nurse was expected to assess the resident, implement medications and/or contact the physician for orders. The 2nd shift Charge Nurse stated that Nurse #1 should have addressed Resident #87 immediately on 07/28/14 when the family notified the nurse that the resident was constipated. The 2nd shift Charge Nurse confirmed that Nurse #1

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 309	Continued From page 21 did not assess Resident #87 on 07/28/14 or notify him of the resident's complaint of constipation until 07/29/14. Review of Resident #87's medical record revealed on 07/29/14 at 11:40PM the resident had a large bowel movement. On 07/31/14 at 12:15 PM the Director of Nursing (DON) was interviewed and reported that Nurse #1 should have gone immediately to check on Resident #87 after the family notified her that the resident was constipated.	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, family interview, staff and resident interviews, the facility failed to change the residents noticeably soiled clothing, failed to provide personal hygiene to residents in need of shaving and mouth care, and failed to keep a resident's fingernails clean and free of debris for 5 or 7 sampled residents dependent with activities of daily living (Resident #86, #22, #40, #108, and #25). The findings included: 1) Resident #86 was admitted to the facility on	F 312	For those residents found to have been affected by the alleged deficient practice, the following corrections took place: - Resident #86 was found wet, with clothes soiled in room and then taken to the Dining room without being changed. After Charge Nurse being informed, resident was removed from dining room, taken to hall bathroom, cleaned and dried. (Corrective action as stated below), to prevent reoccurance, staff involved were disciplined by the Director	8/29/14

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 312	Continued From page 22 02/08/14 with diagnoses which included coronary artery disease, muscle weakness, difficulty walking, dementia, and kidney disease. The Quarterly Minimum Data Set (MDS) dated 05/16/14 indicated his cognition was moderately impaired but was capable of making his needs known. The MDS coded Resident #86 as non-ambulatory, required extensive assistance with his activities of daily living (ADL) including personal hygiene and toileting, and was frequently incontinent of bowel and bladder. The care plan with a revised date of 02/12/14 indicated a problem statement that Resident #86 required assistance with ADLs related to decreased mobility (ability to move freely) and listed approaches in part for staff to anticipate his needs and assist him to the level needed to assure adequate care. Resident #86 was observed on 07/29/14 at 5:10 PM sitting in his wheelchair in his room, dozing off and on, and a strong odor of urine was observed in his room. Further observation revealed Resident #86's pants were soaked with urine and a puddle of urine on the floor under his wheelchair. Resident # 86 was observed on 07/29/14 at 5:16 PM at a table in the dining with his pants soaked with urine. An interview was conducted on 07/29/14 at 5:20 PM with Nursing Assistant (NA) #9. She stated she had not observed Resident #86's pants to be wet when she took him to the dining room.	F 312	of Nursing and/or designee. - Resident #22 was approached by Certified Nursing Assistant on 7-31-2014 after he was viewed with same soiled clothes on. He was resistant to the point of combativeness and would not change his clothes. Later in the day, Certified Nursing Assistant was able to encourage him to change clothes and orange shirt and gray sweat pants were sent to the laundry. As soon as they were returned from the laundry the resident put them back on. The orange sweat shirt and gray sweat pants are the only thing the resident wants to wear. Two more sets of the orange sweatshirts and gray sweat pants have been purchased for the resident. A consult with the RHA psych services has been obtained. Restorative Aide is assigned to the resident each day for assistance with AM care this being monitored by the Director of Nursing and/ordesignee. For resident #108. Oral care was not given to the resident according to resident's statement on 7-31-2014. According to resident, she did not receive oral care on Monday, Tuesday or Thursday, but did receive oral care on Wednesday. The resident was then given care on Friday after breakfast. Staff were reminded to not neglect oral care on the resident again. Verbal warnings were given. A baby toothbrush and gum sensitive toothpaste were purchased for resident. The resident will not allow teeth to be cleaned with regular toothbrush	

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 312	Continued From page 23 An interview was conducted on 07/29/14 at 5:24 PM with NA #8. She indicated she was not the NA assigned to Resident #86 and she was unaware that his pants were wet with urine when she took him out of his room, pushed him into the hallway, and asked NA #9 to take him to the dining room. She further stated the NA assigned to Resident #86 was on her dinner break and the NA's were expected to check residents every 2 hours, before going to their meals, and more often if needed. She revealed she had not checked Resident #86 prior to taking him out of his room. An interview was conducted on 07/29/14 at 5:26 PM with the second shift charge nurse. He stated he expected the NA's to change a resident's soiled clothing immediately. He further stated part of the responsibilities of the NA's were to check on a resident every 2 hours, their clothes are to be changed if they are soiled, and based on the individual resident they may need to be checked and/or changed more often. The charge nurse was observed to interrupt Resident #86's meal, take him out of the dining room, into the hallway bathroom, and was observed to ask NA #8, NA #10, and NA #11 to assist Resident #86 with a change of his clothing. On 07/29/14 at 5:38 PM, the 3 NA's were observed to assist Resident #86 to a standing position from his wheelchair. NA #11 was observed to remove the resident's wet pants, his wet socks, and the soaked brief; which she was observed to use 2 hands to dispose of the heavy brief into the garbage can. NA #10 was observed to wipe and clean the urine off of Resident #86's wheelchair cushion. NA #8 and NA #11 were observed to wash and clean Resident #86, apply a dry clean brief, place dry pants back on	F 312	because of gum disease. Sometimes they can only clean them with toothettes, as the resident allows. Dental consult was ordered for this resident and is being monitored by the Director of Nursing and/or designee. For resident #40, she was found to have chin and lip hairs that had not been removed at bathtime or during AM care. Chin and lip hairs were removed by Assigned Certified Nursing Assistant on 7-31-2014. It is now on her daily care plan for hairs to be removed on bath days and with AM care as needed. this is being monitored by Director of Nursing and/or designee. For resident #25 fingernails found to be dirty and too long. Family that were present at the time cleaned nails. Resident has since been discharged from facility. Director of Nursing or designee. For residents that have the potential for being affected by the alleged deficient practice, assessments were completed and corrective actions initiated (see below) by the Director of Nursing and/or designee. Corrective actions for deficient practices: Assessment for ladies that wish to have facial hair removed waa completed and is reflected on mini care plan sheet. Also a list of residents that do or do not want facial hair removed is in each hall bathroom where showers occur.	

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 312	Continued From page 24 Resident #86, and change his socks. During the observations Resident #86 stated to the NA's "I am worn out and I can't get no one to help me." NA #11 was observed to push Resident #86 back to the dining room and reheat his dinner meal. An interview was conducted on 07/30/14 at 9:07 AM with Resident #86. He stated his brief was changed on 07/29/14 before he went to "bingo" at 2:00 PM. He further stated he was changed again around 5:30 PM. He indicated "it is so aggravating and it happens so often that I have gotten used to being wet." An interview was conducted on 07/30/14 at 10:38 AM with the Director of Nursing (DON). She stated she expected the NA's to change a resident every 2 hours or more often if needed. She further stated she would have expected the NA's to have changed Resident #86 before they took him out of his room. 2) Resident #22 was readmitted to the facility on 06/06/13 with diagnoses which included muscle weakness, schizophrenia, anxiety disorder, seizure disorder, and Parkinson's disease. The Annual Minimum Data Set (MDS) dated 06/11/14 specified Resident #22 had short and long term memory impairment, severely impaired cognitive skills for daily decision making but did not reject care. The MDS further specified Resident #22 required supervision with one person physical assist for his activities of daily living (ADL) including, personal hygiene and toileting but was coded to be totally dependent on staff for bathing. The care plan with a revised date of 03/05/14	F 312	Monitored by DON and/or designee Nail care kits, one for each hall were assembled with fingernail clippers, toenail clippers, files and orange sticks. Alcohol swabs also provided to clean nail clippers after each use. Monitored by DON and/or designee Oral care products provided and consults for dental care obtained as needed Monitored by DON and/or designee Continue to provide needed incontinent care products and assess for correct size of diapers, diapers are readily available by storing in residents closets. Monitored by DON and/or designee Revise and updating careplans for all ADL areas including Incontinance, oral care etc.,as changed occur monitored by Director of Nursing and/or Designee. Inservices was held on 8-13-2014 for Nurses and Certified Nursing Assistants on policies and procedures for ADL care by the Staff Development Coordinator. Disciplinary action as warranted for staff found deficient in ADL policies and procedures by the Director of Nursing and/or designee. Monitoring corretive action to ensure compliance: Audits were completed to assess ladies	

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 312	Continued From page 25 indicated a problem statement that Resident #22 had ADL deficit due to decreased functional status, impaired cognition, and requires assistance with decision-making and listed approaches in part for staff to anticipate his needs and desires, check and change resident approximately every 2 hours and as needed, provide incontinent care as needed, and provide encouragement as needed. Resident #22 was observed on 07/30/14 at 2:23 PM to be ambulating with short sliding steps through the lobby, in and out of the activity room, and up and down the hallways with his peri-abdominal epigastric (PEG) tube to be hanging below the hem of his orange colored sweatshirt which was observed to have a 4 x 4 rounded type wet stain on the front and with continued observations he was wearing a gray pair of sweatpants with tan stains at the crotch area, down the legs of his pants, and brown stains on the buttocks. Resident #22 was observed on 07/30/14 at 4:48 PM to be ambulating down the hall with the same orange stained sweatshirt and the same gray stained sweatpants. Resident #22 was observed on 07/31/14 at 7:34 AM to be wearing the same stained orange sweatshirt and gray stained sweatpants. An interview was conducted on 07/31/14 at 7:38 AM with Nursing Assistant (NA) #14. She stated Resident #22 was capable of changing his clothes but would occasionally refuse. She indicated routine resident care was expected of the NA's every morning before a resident ate breakfast. She specified routine resident care	F 312	that are care planned for facial hair removal - audits daily x 2 weeks, twice weekly x 2 weeks and monthly x 2. Review will occur monthly at monthly and quarterly QAPI meeting to determine effectiveness. Reviewed by Director of Nursing and/ or designee/Compliance Officer. Audits for fingernail care being completed daily x 2 weeks, twice x 2 weekly and monthly x 2. Nail Kits have been made for each hall with hall nurses on 1st and 2nd shift being responsible for giving them to the Certified Nursing Assistants at the beginning of the shift and ensuring they are returned at the end of the shift. Each hall has a checklist to sign by nurses to say Nail kits have been returned to medication room. Review will occur at monthly and quarterly QAPI Meetings to determine effectiveness by the Director of Nursing and/or designee/Compliance Officer. Audits for oral care are being conducted daily x 2 weeks, twice weekly x 2 weeks, then monthly x 2. Audits will be reviewed at monthly and quarterly QAPI meetings to determine effectivenss and revised if needed by the Director of Nursing and/ or designee/Compliance officer. Audits for overall ADL care and needs of residents being met, are conducted daily by assigned hall nurses. One Administrative Nurse is assigned a specific hall each day to make additional rounds. They are to identify issues or	

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 312	Continued From page 26 consisted of checking a resident, wash their face and hands, change the resident's brief, and change their clothes if they were soiled. She indicated Resident #22 was "in one of his moods" the day before and he would not allow her to provide any resident care. She further indicated she was aware of his stained and soiled clothing but she had not approached him or attempted to change his clothes. An interview was conducted on 07/31/14 at 7:48 AM with NA #7. She stated Resident #22 was capable of changing his clothes but it depended on the way he was approached whether he would accept the NA's help. She further stated the NA's was expected to assist Resident #22 with his cleanliness and if he refused care the nurse was supposed to be informed. She indicated she had not been in Resident #22's room nor had she approached him about changing his clothes. An interview was conducted on 07/31/14 at 10:15 AM with NA #4. She stated she had given Resident #22 a shower on 07/29/14 and assisted him to put on the orange sweatshirt and gray sweatpants. She indicated he had refused care occasionally but he had not refused care with her. She indicated the clothes Resident #22 had on was what she had assisted him with after his shower. She stated the NA's were expected to change his clothes daily and provide care to him as needed. An interview was conducted on 07/31/14 at 11:54 AM with Nurse #3. She stated she expected the NA's to change Resident #22's clothes daily and to inform her if he refused care. She further stated she was unaware of Resident #22 refusing care in the past several days.	F 312	problems and correct. They are to re-educate or give disciplinary action as warranted. This is Ongoing, daily and is the responsibility of Administrative Nurses and hall Nurses. Continuing Inservice training for ADL Care according to Policies and Procedures will occur at least 2x yearly and as needed. Training will also occur with all new hire nurses and Certified Nursing Assistants during the orientation process by the Staff Development Coordinator.	

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 312	Continued From page 27	F 312		

An interview was conducted on 07/31/14 at 12:23 PM with the Director of Nursing (DON). She stated she expected the NA's to change a dependent residents' clothing daily and as needed. The DON confirmed it was her expectation that Resident #22 should have had his clothing changed daily.

3. Resident #40 was admitted to the facility on 01/19/11 with diagnoses which included difficulty walking, generalized muscle weakness, dementia, anxiety state, generalized pain, debility, and Alzheimer's.

The annual Minimum Data Set (MDS) dated 01/13/14 coded Resident #40 as severely impaired cognitively for daily decision making skills but she was able to make herself understood and understands others. The MDS coded Resident #40 as nonambulatory and dependent on staff for extensive assistance for all activities of daily living (ADL) including, grooming, eating and toileting.

Review of the current care plan dated last revised 07/14/14 revealed the identified problem for ADL deficit due to dementia. The goal for Resident #40 was to remain clean and neat and to have her needs and desires met. The interventions included to anticipate Resident #40 ' s needs and desires and to assist and provide her with ADL to assure adequate care.

Review of the resident bath and daily care sheets

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 312	Continued From page 28	F 312		

for July 2014 revealed shaving was not checked off for being provided.

On 07/28/14 at 3:15 PM Resident #40 was observed in bed with the covers on up to her waist. Resident #40 was observed with a few facial hairs present on her chin that were 1½ inch long gray hairs, three gray hairs about ½ to 1 inch long at the corner of her right upper lip and ¼ inch long darker hairs on the length of her upper lip.

On 07/29/14 at 9:10 AM Resident #40 was observed sitting up in her wheelchair in her room. The facial hairs were observed still present on her chin and upper lip.

On 07/29/14 at 3:58 PM Resident #40 was observed resting in bed with the facial hair still present on her chin and upper lip.

On 07/30/14 at 8:17 AM Resident #40 was observed in the dining room having her breakfast and the facial hair was still present on her chin and upper lip.

On 07/31/14 at 7:41 AM Resident #40 was observed in the dining room awaiting her breakfast to be served and the facial hair was still present on her chin and upper lip.

During an interview on 07/31/14 at 9:19 AM with Nursing Assistant (NA) #6 Resident #40 was observed with facial hair on her chin and upper lip. NA #6 observed the facial hair present and Resident #40 exclaimed " Oh my, not beard hairs, don ' t find anymore and get rid of them. " The NA stated Resident #40 required total assistance for all ADLs including bathing and

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 312	Continued From page 29	F 312		

shaving. NA #6 revealed shaving is normally completed on shower days but was also included in morning care and grooming. NA #6 verified she had not shaved Resident #40 ' s facial hair this week.

During an interview on 07/31/14 at 9:21 AM Nurse #3 verified the facial hair was present on Resident #40. Nurse #3 stated it was her expectation for facial hair to be removed as a part of the morning care provided for Resident #40.

During an interview on 07/31/14 at 12:07 PM Charge Nurse #1 confirmed it was her expectation that NAs remove facial hair either on the Residents ' shower day or with their morning care. Charge Nurse #1 further stated it was her expectation facial hair removal was considered grooming and was completed during the shower or as part of morning ADLs.

During an interview on 07/31/14 at 12:37 PM the Director of Nursing (DON) stated that morning care for residents requiring total assistance with ADLs included facial hair removal, face and hand washing, and oral care. The DON confirmed it was her expectation Resident #40 should have had the facial hair shaved on her shower day or as part of the morning care and it was the responsibility of the NA assigned to the resident to provide this care daily.

4. Resident #108 was readmitted to the facility on 12/13/13 with diagnoses which included peripheral vascular disease, generalized muscle weakness, difficulty walking, depressive disorder, generalized pain, osteoarthrosis, anxiety, and rheumatoid arthritis.

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 312	Continued From page 30	F 312		

The quarterly Minimum Data Set (MDS) dated 03/21/14 coded Resident #108 was cognitively intact for daily decision making skills. The MDS coded Resident #108 as nonambulatory and dependent on staff for extensive assistance for all activities of daily living (ADL) including, grooming, eating and toileting. The MDS indicated Resident #108 had impaired range of motion to both sides of her upper and lower extremities.

Review of the Nursing admission assessment dated 12/14/13 coded Resident #108 with no history of behaviors related to the provision of care. The assessment further coded Resident #108 with impaired mobility and range of motion to both of her hands and arms and dependent on staff for all ADL including oral care. Resident #108 ' s oral dental status revealed some natural teeth lost.

Review of the current care plan last revised 06/07/14 identified the problem of carious (cavities) teeth. The goal developed was for Resident #108 to eat & drink without pain. The care plan for Resident #108 revealed an intervention to provide oral hygiene daily and as needed.

On 07/28/14 at 03:05 PM Resident #108 was observed in her room in bed watching a movie. Resident #108 ' s teeth were observed to have white matter accumulated along the gum line and between the teeth of her upper and lower teeth. She stated she had not had her teeth cleaned today.

On 07/29/14 at 9:34 AM Resident #108 was observed after breakfast resting in her bed

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 312	Continued From page 31	F 312		

sleeping with her mouth wide open. Resident #108 ' s teeth were observed to have white matter accumulated along the gum line and between the teeth of her upper and lower teeth.

On 07/31/14 at 12:00 PM Resident #108 was observed seated in her wheelchair and reported that she had received her morning care but that it did not include cleaning her teeth. Resident #108 ' s teeth were observed to have visible white matter accumulated along the gum line and between the teeth of the upper and lower teeth.

During an interview on 07/31/14 at 12:00 PM Resident #108 stated she had not had her teeth cleaned every morning. Resident #108 further stated she was unable to do her own care due to her limited mobility of her arms and hands. Resident #108 revealed the NA cleaned her teeth on Wednesday and further stated her teeth were not cleaned at any time on Monday, Tuesday or Thursday. Resident # 108 stated she would like to have her teeth cleaned and face and hands washed everyday.

During an interview on 07/31/14 at 12:00 PM Nursing Assistant (NA) #7 stated she was familiar with and was assigned to Resident #108 ' s care. NA #7 further stated that other NAs had gotten Resident #108 up those mornings. NA #7 confirmed she was ultimately responsible for the morning care for Resident #108 and had not provided oral care on Monday, Tuesday or Thursday mornings.

During an interview on 07/31/14 at 9:21 AM Nurse #3 stated it was her expectation for Resident #108 to have oral care every morning as a part of her morning care which was provided

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 312	Continued From page 32	F 312		

by NAs.

During an interview on 07/31/14 at 12:07 PM Charge Nurse #1 confirmed it was her expectation that NAs provided oral care as a part of the morning care provided for all dependent residents.

During an interview on 07/31/14 at 12:37 PM the Director of Nursing (DON) stated that oral care was ultimately the responsibility of the NA assigned to each dependent resident. The DON revealed that morning care for residents requiring total assistance with ADLs included face and hand washing, and oral care. The DON confirmed it was her expectation Resident #108 should have had her teeth cleaned daily.

5. Resident #25 was admitted to the facility on 08/20/09 with diagnoses that included Alzheimer's disease and others. The most recent Minimum Data Set (MDS) dated 07/17/14 specified the resident had short and long term memory impairment, severely impaired cognitive skills for daily decision making but did not reject care. The MDS also specified the resident required extensive assistance with personal hygiene. Resident #25's activities of daily living (ADL) care plan updated 07/18/14 identified the resident had an ADL deficit related to decreased functional status. Interventions on the care plan specified nurse aides were to provide assistance and "keep nails clean and trimmed short."

On 07/28/14 at 11:15AM Resident #25's family was visiting the resident. Resident #25's fingernails on her right hand were observed and revealed they had brown debris accumulated underneath. The family stated they often found

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 312	Continued From page 33 the resident's nails dirty with brown debris. The family proceeded to clean the nails. On 07/28/14 at 2:40 PM nurse aide (NA) #1 was interviewed and reported that she routinely cared for Resident #25. NA #1 explained that the resident did not reject care. NA #1 added that nail care was provided on shower days but nurse aides were to inspect nails daily and address concerns as needed. NA #1 reported that she had provided Resident #25's morning care but did not clean the resident's fingernails because she was busy. On 07/31/14 at 12:00 PM the Director of Nursing (DON) was interviewed and reported that she expected nurse aides to clean and trim residents' fingernails daily and as needed. The DON added that she recently equipped each hall with nail kits and educated nurse aides on the importance of daily nail care. The DON added that she expected nurse aide #1 to have cleaned Resident #25's nails during morning care.	F 312		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		8/29/14

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 441	Continued From page 34 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to disinfect 2 blood glucose meters that were stored in individual storage boxes and labeled with resident names but had a different resident name on the blood glucose meters inside the storage boxes in 1 of 4 medication carts. The findings included: A review of a facility policy titled Medications - Administration with a revised date of 2014	F 441	For resident #65 and #96 who could have been affected by this alleged deficient practice, the involved glucometers were all cleaned with approved Germicidal Cleaner, then labels were corrected. This was monitored by the Director of Nursing and/ or designee. Any Resident with the potential to be affected by this alleged deficient practice: All Glucometers were checked and there were no other ones mislabeled.	

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 441	Continued From page 35 indicated under #8. Each resident is to be allocated their own glucometer for glucose testing. (See cleaning glucometer policy). A review of a facility policy and procedure titled glucometer cleaning with a revised date of 04/2014 indicated the following policy statement: It is the facility policy to provide each resident with their own blood glucose meter for glucose testing and to help prevent the spread of infectious diseases from resident to resident. The procedure was listed as follow: 1. When the licensed nurse receives an order for glucose testing, the resident will be provided with their own glucose meter. 2. If the resident's personal glucometer is visibly soiled, it may be cleaned with an alcohol wipe. The resident's personal glucometer must only be used for that resident. 3. If a resident expires or is discharged from the facility the glucose meter will be placed in a basket with a red label in designated cabinet in medication room. 4. Inventory and supply controller will pick up the glucose meters periodically for cleaning with approved disinfectant for blood-borne pathogens and place in storage for reuse. 5. Back up glucose meters will be available (new or sanitized with a blood-borne pathogen effective cleanser). A review of the instructions provided by the manufacturer of the disinfectant germicidal disposable wipes indicated an overall contact time of 3 minutes to disinfect microorganisms. An observation was conducted on 07/31/14 at 10:35 AM of medication storage in the B Hall medication cart with nurse aide (NA) #5 who was	F 441	Glucometers were also checked for cleanliness and all were clean. This was monitored by Director of Nursing and/or designee. Corrective Actions: Inservice training for Nurses and Med-aides on the proper labeling and cleaning of Glucometers on 8-13-2014. They were also instructed to take one glucometer out of cart at a time, replacing it before getting another one out. This was conducted by the Staff Development Coordinator. Reviewed policies and found them to be in compliance with the standards for using and cleaning Glucometers. This was done by the Director of Nursing and the Infection Control Nurse Checked stock to assure new or disinfected Glucometers were always available. Some are always kept in medication room cabinet. This was done by the Infection Control Nurse. Infection Control Nurse also scheduled to attend SPICE program training in Chapel Hill in September for latest update in infection control. Monitoring Corrective Actions: All Glucometers are audited daily by each shift for correct labeling and cleanliness. A check off sheet is in the Narcotic book on each cart with resident's	

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 441	Continued From page 36 also a medication aide. She demonstrated glucose meters were stored in individual boxes in the drawers of the medication cart and had a piece of tape attached to the outside of the box with resident's name written with a black marker on a piece of tape. Upon inspection of glucose meters inside the boxes, 1 storage box had Resident #65's name on the piece of tape attached to the outside of the box but the glucose meter had Resident #33's name written in black ink on a piece of tape attached to the back of the glucose meter. A second storage box had Resident #96's name written in black ink on a piece of tape attached to the outside of the box but the glucose meter inside the box had Resident #22's name written in black ink on a piece of tape attached to the back of the glucose meter. During an interview on 07/31/14 at 10:40 AM with NA #5 and she stated she routinely worked the 7:00 AM to 3:00 PM shift and she had not seen the name discrepancies on the storage boxes and glucose meters until now. She stated it was her usual practice to clean the individual glucose meters with alcohol wipes before and after use but since the glucose meters were mixed up they should be cleaned with the disinfectant germicidal wipes located in the medication room. She further stated she had not used either of the 2 glucose meters yet today but thought they had been used earlier that morning by the third shift nurse and they would have to be cleaned with the disinfectant germicidal wipes before she could use them since she didn't know which glucose meter had been used for which resident. During an interview on 07/31/14 at 11:01 AM with the inventory and supply controller who was	F 441	names for that hall that have Glucometers. Audits to be done ongoing (daily) with reports to the monthly and quarterly QAPI Meeting and review is done x 3 months. This is monitored by the Director of Nursing/Infection Control Nurse Infection Control Nurse will audit the carts also and the nurses and medaides audit sheets to ensure measures are being followed, weekly x 2, x 2 monthly. - Infection Control Nurse will audit the carts. The Nurses and Med-aide audit sheets to ensure measures are being followed weekly x 2, 1 x monthly, x 2 months, and then reviewed monthly and quarterly at the QAPI meetings to assess for effectiveness. Director of Nursing/Infection Control Nurse. - Continuing inservices on infection control and with all new hires during orientation and x 2 yearly and as needed. Staff Development Coordinator or designee.	

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 441	Continued From page 37	F 441		

responsible for cleaning glucose meters she explained several months ago the facility assigned glucose meters to each resident who had orders for blood glucose checks. She further explained she was responsible for cleaning glucose meters with the disinfectant germicidal wipes when a resident expired or was discharged from the facility but if a glucose meter needed to be cleaned with the disinfectant germicidal wipe nursing staff should leave it in the basket with a red label in the medication room designated for cleaning glucose meters. She stated she was not aware that 2 glucose meters had a resident's name on the storage box but a different name on the glucose meter inside the box and verified she had not been asked by nursing staff to clean either of the glucose meters with the disinfectant germicidal wipes.

During an interview on 08/01/14 at 6:42 AM with Nurse #4 she verified she had checked Resident # 65's blood sugar at 6:00 AM on 07/31/14 and she used the glucose meter inside the storage box labeled with Resident #65's name written on the piece of tape on the outside of the box. She stated she did not realize Resident # 33's name was written on a piece of tape on the back of the glucose meter because she did not turn it over to look at it. She also verified she had last checked Resident #96's blood sugar at 6:00 AM on 07/30/14 and used the glucose meter inside the storage box labeled with his name but did not realize Resident #44's name was on a piece of tape on the back of the glucose meter. She explained she cleaned both of the glucose meters with an alcohol wipe before and after she used them but she should have used the disinfectant germicidal wipes to clean them since the glucose meters were mixed up and were not in the correct

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 441	Continued From page 38 storage boxes. She further explained she had not checked blood sugars for Resident's #33 or #44 because they only had blood sugar checks on a monthly basis and they were not due to have them checked yet. She stated she did not have any explanation as to why the resident name on the outside of the storage box was different than the name on the glucose meter and she had not had this happen before now. During an interview on 08/01/14 at 7:12 AM with Nurse #5 who was also a night shift nursing supervisor explained since the facility had switched to individual glucose meters for resident use nurses and medication aides were supposed to write the resident's name on a piece of tape and attach it to the outside of the storage box so that they would only use the glucose meter that had been assigned to the resident. She stated both glucose meters should have been cleaned with the disinfectant germicidal wipes before they were used for Resident #65 and Resident #96 to prevent cross contamination. During an interview on 08/01/14 at 8:02 AM the Director of Nursing (DON) explained she had done an audit of glucose meters last week and all glucose meters were in the correct storage box with the resident's name written in black ink on the outside of the box. She stated it was her expectation for the storage box to be clearly labeled with the resident's name and contain the glucose meter assigned to that resident and if there was any discrepancy with resident names, the glucose meter had to be cleaned with the disinfectant germicidal wipes before it was used to check the resident's blood sugar.	F 441		
F 520	483.75(o)(1) QAA	F 520		8/29/14

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 520 SS=D	Continued From page 39 COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews the facility failed to implement and monitor interventions put into place by the Quality Assessment and Assurance committee for privacy and confidentiality and infection control related to disinfection of blood glucose meters. (Resident #10, and 1 of 4 medication carts).	F 520	For resident #10 (cross reference to F-164), that facility had failed to ensure residents Privacy, that had been a cited deficient practice on previous survey. Resident was interviewed and again informed of his right to private conversations. Resident stated I have had no problems with that issue. For residents that have the potential to be	

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 520	Continued From page 40 The findings included: 1. Cross refer to F-164. Based on observations, record review, resident interview, and staff interviews the facility failed to ensure a resident's privacy with a surveyor for 1 of 1 residents reviewed for privacy and confidentiality (Resident #10). During an interview on 08/01/14 at 3:54 PM the Administrator stated she expected staff to ensure a resident's privacy. She explained the frequency of Quality Assurance (QA) meetings had been increased to monthly meetings and their action plans had been driven by the plan of corrections they developed as a result of the previous surveys. She further explained items for discussion at the QA meetings were also added when staff noticed things during rounds or audits and she also put items on the agenda that she wanted addressed. She stated it had been hard to prioritize action plans because there was so much that needed to be corrected. She further stated it was her expectation for issues to be resolved and corrected and they would have to continue ongoing training and in-servicing of staff to achieve compliance. 2. Cross refer to F-441. Based on observations, record reviews and staff interviews the facility failed to disinfect 2 blood glucose meters that were stored in individual storage boxes and labeled with resident names but had a different resident name on the blood glucose meters inside the storage boxes in 1 of 4 medication carts. During an interview on 08/01/14 at 8:02 AM the Director of Nursing (DON) explained she had	F 520	affected by same cited practice, actions have been taken to prevent reoccurrence. (See Below) - For residents that could have potentially been affected by the mislabeling of glucometers: All Glucomets have been cleaned and relabeled correctly (cross reference F441) Actions have been taken to prevent reoccurence of cited deficient practice (See Below) Corrective Actions: - All previously cited practices (in last 3 months) will be reviewed at monthly and quarterly QAPI meetings. If any issues with same cited practices, then new interventions, policies or procedures will be put into place to correct deficient practice. Administrator/Director of Nursing/Compliance Officer. - Inservice training for cited practices was conducted on 8-13-2014 and Administrative QAPI members were in attendance. Staff Development Coordinator. - Review of cited deficient practices discussed each AM in stand-up Meeting with actions for correction discussed. Ongoing until compliance achieved. Director of Nursing or designee Audits will be conducted on all alledged cited deficient practices as outlined in this Plan of Correction. Director of Nursing or designee/Compliance officer.	

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 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET 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 520	Continued From page 41 done an audit of glucose meters last week and all glucose meters were in the correct storage box with the resident's name written in black ink on the outside of the box. She stated it was her expectation for the storage box to be clearly labeled with the resident ' s name and contain the glucose meter assigned to that resident and if there was any discrepancy with resident names, the glucose meter had to be cleaned with the disinfectant germicidal wipes before it was used to check the resident's blood sugar. During an interview on 08/01/14 at 3:54 PM the Administrator stated after the last survey they bought glucometers for every resident who had orders for finger stick blood sugars and labeled them and thought they had the problems fixed related to disinfection of blood glucose meters. She explained the frequency of Quality Assurance (QA) meetings had been increased to monthly meetings and their action plans had been driven by the plan of corrections they developed as a result of the previous surveys. She further explained items for discussion at the QA meetings were also added when staff noticed things during rounds or audits and she also put items on the agenda that she wanted addressed. She stated it had been hard to prioritize action plans because there was so much that needed to be corrected. She further stated it was her expectation for issues to be resolved and corrected and they would have to continue ongoing training and in-servicing of staff to achieve compliance.	F 520	Mock Surveys will be conducted to identify problems that may reacur 2 x monthlyy x 3 months. Discuss at monthly and quarterly QAPI Meetings with an action plan formulated for problems identified. Director of Nursing or designee/Compliance Officer. Continue inservicing on problems or issues identified by QAPI Process as needed. Staff Development Coordinator or designee. Quality Assurance rounds to continue by Administrative Nurse 5 x weekly, ongoing. Administrative Nurses, Director of Nursing or designee.	