STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345501	A. BUILDING _____ B. WING _____	C 07/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROASDAILE VILLAGE	2600 CROASDAILE FARM DURHAM, NC 27705

(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 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to implement their care plan to initiate a chair alarm for 1 of 3 sampled residents reviewed for accidents (Resident #157). The findings include: Resident #157 was admitted to the facility on 01/18/11 and had diagnoses including Alzheimers Disease, Osteoporosis and Osteoarthritis and Depression. The Care Area Assessment (CAA) for Cognitive Loss/Dementia dated 2/8/11 showed that the resident had cognitive loss secondary to short and long term memory loss. The CAA for Falls dated 2/8/11 showed that the resident was at risk for falls due to antidepressant medications. The Quarterly Minimum Data Set (MDS) Assessment dated 04/25/11 showed that the resident had short and long term memory loss and had difficulty making decisions in new situations. The MDS showed that the resident had experienced one fall since admission with no injury. The resident ' s care plan updated 6/6/11 showed that the resident was at risk for fall related	F 282	Croasdaile Village acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of Quality of Care of residents. The Plan of Correction is submitted as a written allegation of compliance. Preparation and submission of this Plan of Correction is in response to the CMS 2567 from the July 13, 2011 survey. Croasdaile Village's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Croasdaile Village reserves the right to refute any deficiency on this Statement of deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative or legal procedures. #1 For resident #157 an order (please see attachment #1) was written for a chair alarm while the resident is in her chair, wheelchair or recliner. Use of chair alarm is noted on the resident's care plan and interim careplan (please see attachment #2). A chair alarm was placed on the resident's chair.	7-14-2011

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

TITLE: Healthcare Administrator

(X6) DATE: 7-26-11

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PRINTED: 07/19/2011
FORM APPROVED
OMB NO. 0938-0391

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

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CROASDAILE VILLAGE	2600 CROASDAILE FARM DURHAM, NC 27705

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F 282	Continued From page 1 injuries. The approach column contained an entry dated 6/6/11 that read: " Chair alarm at all times in w/c (wheelchair). " The entry was signed by social worker #1. The Interim Care Plan posted on the inside of the resident ' s closet door in the room revealed that the resident was to have a chair alarm at all times in chair. A Nurse ' s Note dated 06/06/11 read in part: " Patient reviewed with IDT (Interdisciplinary Team) for fall risk. Chair alarm added to care plan to keep on w/c (wheelchair) at all times. " The note was signed by Social Worker #1. Resident #157 was observed in a wheelchair in the dining room on 07/13/11 at 12:00 Noon. There was not a chair alarm observed on the resident ' s wheelchair. Nursing Assistant #1 stated in an interview on 07/13/11 at 1:36 PM that resident #157 did not have an alarm on her wheelchair. The Director of Nursing (DON) stated in an interview on 07/13/11 at 2:27 PM that the Falls Committee consisted of the administrator, the DON, therapy, the social worker and the 2 MDS nurses. The DON stated that this resident was observed on the floor in front of her wheelchair on 06/05/11 after trying to self transfer from the wheelchair to a recliner. The DON stated that the decision was made during a falls committee meeting on 06/06/11 to put a chair alarm on the resident ' s wheelchair. The DON stated that there was a care plan on the inside of each resident ' s closet door to inform the nursing assistants of any changes in care.	F 282	#2 The Administrator in Training conducted an audit (please see attachment #3) for each resident who experienced a fall with a noted intervention for alarm placement on the IDT-Risk Team Post Fall Assessment covering January 2011 through present. The audit was conducted to ensure orders were written for any bed or chair alarm; the alarms were noted on the resident careplans; and interim careplan located inside the residents' closet; and the alarm is in place and working properly. Audit will be reviewed by Director of Nursing or designee and follow up actions implemented to ensure proper documentation is in place. #3 The Quality Assurance Chairperson or designee is conducting weekly audits (please see attachment #3) on randomly chosen residents with alarms to ensure orders and proper documentation is in place. A light has been added to the Caretracker system to ensure C.N.A.s are reviewing the residents' interim careplans, which are located in their armoires. A light has been added to the Caretracker system to ensure C.N.A.s are checking resident alarms and that they are working properly.	7-28-2011 7-27-2011 7-20-2011 7-22-2011

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F 282	Continued From page 2 Nursing Assistant (NA) #1 stated in an interview on 07/13/11 at 2:36 PM that the nursing assistants do walking rounds at shift change with the nursing assistant from the previous shift and are updated with any changes in the resident ' s plan of care. The NA again stated that this resident did not have a chair alarm for her wheelchair. During the interview an observation was made of the resident ' s wheelchair in the resident ' s room. There was no alarm on the wheelchair. Nurse #1 stated in an interview on 07/13/11 at 2:40 PM that Resident #157 did not have a chair alarm on her wheelchair. The Nurse stated that if an alarm was used for a resident there was an order on the Medication Administration Record (MAR) to let her know to check the alarm. There was not an entry on the MAR or a physician ' s order for a chair alarm to be on the resident ' s wheelchair. Social Worker #1 stated in an interview on 07/13/11 at 2:46 PM that she was responsible for adding the chair alarm to the care plan and that the MDS nurse would write a physician ' s order for the chair alarm. On 07/13/11 at 2:55 PM an interview was conducted with the 2 MDS nurses. MDS Nurse #1 stated that the medical records of the residents reviewed by the falls committee were taken to the meeting and the physician ' s order for the chair alarm would have been written during the meeting. The MDS Nurses were observed to look through the physician ' s orders and stated they could not explain why the order was not written. MDS Nurse #2 stated that this one just fell	F 282	A Falls Committee Assignment spread-sheet was created to ensure that each member of the team is aware of their respective assignments. The MDS Assistant or designee will be responsible for writing all physician orders for alarms. Falls Committee Chairperson will scan and email Committee minutes following each Committee meeting to administration, nurse management, medical team and pharmacy consultant. A Quality Assurance form (please see Attachment #4) has been created for Falls Committee members to audit records following the Falls Committee meeting to ensure that proper documentation is in place. #4 Quality Assurance Committee will review the audit results and follow up on any action plans during the Quality Assurance Committee meeting. Any items on the action plan will be completed to ensure continued compliance. Quality Assurance Committee will determine if any further education is needed based on results of audits. The Quality Assurance Committee has the right to discontinue the audits once the committee determines compliance has been achieved.	7-25-2011 7-27-2011 7-27-2011

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F 282	Continued From page 3 through the cracks.	F 282		

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K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 7/29/11 at approximately noon the following corridor doors were non-compliant, specific findings include; physical therapy and trash room doors had a dead bolt that required more than one range of motion to exit the area.	K 018	**K018** **Corrective Action:** Maintenance Department contracted with local door company to replace existing rehabilitation entrance door lock. The deadbolt will be removed. A new lock with single motion action will be installed along with an electric door strike for the automatic door opener. The locksmith reinstalled the hardware on the door of the basement trash room to correct positive latching. **Identifying Life Safety Issues:** The Maintenance Director will complete an audit of all doors in the Pavilion to ensure that they meet Life Safety requirements for single motion door opening and positive latching.	8-26-2011 8-12-2011 8-29-2011
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8	K 045		

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

Jennifer Jacking | Healthcare Administrator | 8-18-11

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K 045	Continued From page 1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 7/29/11 at approximately noon the following exit discharge illumination was observed as non-compliant; specific findings include a single bulb fixture at the exit near room E109. Lighting must be arranged to provide light from the exit discharge leading to the public way (parking lot). The walking surfaces within the exit discharge shall illuminated to values of at least 1 ft-candle measured at the floor. Failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candles in any designated area. NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4.	K 045	**Systemic Changes:** Maintenance Director or designee will utilize preventative maintenance software to generate a monthly work order (Attachment #1) to audit all Pavilion doors to ensure positive latching and single motion action to exit. **Monitored:** The results of the monthly audits will be presented during Quality Assurance meetings. **K045** **Corrective Action:** Maintenance Department contracted with a local company to replace all single bulb fixtures at the exits and replace them with the double bulb fixtures. **Identifying Life Safety Issues:** The Maintenance Director completed an audit of all the exit areas to ensure that the single bulb fixtures have been changed to the double bulb fixture (Attachment #2).	9-1-2011 8-12-2011 8-16-2011
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: 42 CFR 483.70(a)	K 052		

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K 052	Continued From page 2 A. By observation on 7/29/11 at approximately noon, during the inspection and testing of the facility fire alarm system, that consisted of multiple components, the back up battery, when placed in trouble by disconnecting, did not send a troublesignal to the main fire alarm control panel (FACP). B. By document review on 7/29/11 at approximetely noon, the annual certification to the fire alarm system noted that the audio/visual strobe light located in the laundry room, S06, did not function during testing.	K 052	**Systemic Changes:** Maintenance Director or designee will utilize preventative maintenance software to generate a monthly work order (Attachment #3) to audit all Pavilion exit doors to ensure double bulb fixtures are in place. **Monitored:** The results of the monthly audits will be presented during Quality Assurance meetings.	8-17-2011
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066	**K052** **Corrective Action:** Simplex inspected the back-up battery and found improperly installed jumper wire. Removed jumper wire. The technician unplugged back-up batteries and 60 seconds later the trouble alert Showed on main fire panel display. The audio/visual strobe light located in the laundry room, S06, was replaced by Simplex.	8-2-2011 8-2-2011

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K 066	Continued From page 3 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 7/29/11 ashtrays of noncombustible material and safe design per paragraph 3 above were not provided.	K 066	**Identifying Life Safety Issues:** Simplex tested the back-up battery and audio/visual strobe, and both were in working order. **Systemic Changes:** Maintenance Director or designee will utilize preventative maintenance software to generate a monthly work order (Attachment #4) to audit the back-up battery to ensure that it sends a trouble signal to the main fire alarm control panel (FACP). Simplex completes an annual inspection of the fire system. A preventative maintenance work ordered (Attachment #5) has been generated for maintenance to contact Simplex in February regarding the annual inspection. **Monitored:** The results of the monthly audits will be presented during Quality Assurance meetings. The results of the Simplex audit will be presented to the Quality Assurance Committee following the annual inspection.	8-2-2011 8-18-2011 8-18-2011
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 7/29/11 at approximately noon the following exit egress was observed as non-compliant; specific findings include scooter charging in the exit corridor near room E109.	K 072		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	Continued From page 4 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 7/29/11 at approximately noon the following operational inspection and testing was non-compliant. Specific findings include: documentation for monthly load test was conducted without recording percent rated load or temperature rise. A load bank test had not been completed within the past year. NFPA 99 3-4.4.2 Record keeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110 6-4.2 (1999 edition) generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. NFPA 110 6-4.2.2 (1999 edition) Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPPS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. (load	K 144	**K066** **Corrective Action:** Central Supply ordered a new ashtray of noncombustible material and safe design. The new ashtray has been placed in the designated smoking area. **Identifying Life Safety Issues:** There is only one designated smoking area on the Croasdaile Village campus. The Director of Security confirmed (Attachment 6) that the noncombustible ashtray is in the smoking area. **Systemic Changes:** Maintenance Director or designee will utilize preventative maintenance software to generate a monthly work order (Attachment 7) to audit the smoking area to ensure that the noncombustible ashtray remains in this area. **Monitored:** The results of the monthly audits will be presented during Quality Assurance meetings.	8-17-2011 8-18-2011 8-17-2011

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K 144	Continued From page 5 bank testing)	K 144	K072 **Corrective Action:** All personal mobility devices have been removed from the hallways.	8-18-2011
K 160 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2 This STANDARD is not met as evidenced by: By observation on 7/29/11 at approximately noon the following item was non-compliant with ANSI, specific findings include the annual elevator inspection was last completed in June of 2010.	K 160	**Identifying Life Safety Issues:** Administrator or designee will complete walking rounds to ensure that all personal mobility devices have been removed from the halls and stored properly. **Systemic Changes:** Current residents and future residents will sign a letter of understanding (Attachment ; 8) that personal mobility devices are to remain in his/her room or placed in a location designated by the facility. Administrator or designee will utilize preventative maintenance software to generate a monthly work order (Attachment : 9) to audit to ensure that personal mobility devices are not parked in the halls or blocking a means of egress.	8-22-2011 8-22-2011 8-17-2011

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K 144	Continued From page 5 bank testing)	K 144	**Monitored:** The results of the monthly audits will be presented during Quality Assurance meetings. K144	
K 160 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2 This STANDARD is not met as evidenced by: By observation on 7/29/11 at approximately noon the following item was non-compliant with ANSI, specific findings include the annual elevator inspection was last completed in June of 2010.	K 160	**Corrective Action:** Gregory Poole Electric Co. completed a load bank test (Attachment 10) on the facility's generator. Maintenance Director or designee will add the percent rated load and temperature rise to the monthly audit that is currently being conducted (Attachment 11). **Identifying Life Safety Issues:** The facility has only one generator that is checked monthly by the maintenance department. The load bank test will be completed annually.	8-10-2011 8-18-2011 8-18-2011

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K 144	Continued From page 5 bank testing)	K 144	**Systemic Changes:** Maintenance Director or designee will add the percent rated load and temperature rise to the monthly audit that is currently being conducted (Attachment #11).	8-18-2011
K 160 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2 This STANDARD is not met as evidenced by: By observation on 7/29/11 at approximately noon the following item was non-compliant with ANSI, specific findings include the annual elevator inspection was last completed in June of 2010.	K 160	Maintenance Director or designee will utilize preventative maintenance software to generate an annual work order in April (Attachment 12) to conduct the load bank test. **Monitored:** The results of the monthly audits will be presented during Quality Assurance meetings. The results of the load test will be presented annually during the Quality Assurance meeting. **K160** **Corrective Action:** The NCDOL inspected the elevators. The certifications are posted in each elevator (Attachment #13)	8-17-2011 8-3-2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345501	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROASDAILE VILLAGE	2600 CROASDAILE FARM DURHAM, NC 27705

(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
K 144	Continued From page 5 bank testing)	K 144	**Identifying Life Safety Issues:** Maintenance Director audited both elevators to ensure certificate were updated and posted (Attachment 14).	8-16-2011
K 160 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2 This STANDARD is not met as evidenced by: By observation on 7/29/11 at approximately noon the following item was non-compliant with ANSI, specific findings include the annual elevator inspection was last completed in June of 2010.	K 160	**Systemic Changes:** Maintenance Director generated a work order (Attachment # 15) to contact the NCDOL in April to schedule the elevator inspections. **Monitored:** The results of the annual audit will be presented to the Quality Assurance Committee.	8-1-2011