accepted per fax.

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 06/07/2012

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 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 and staff interviews, the facility failed to provide privacy of confidential records during medication administration for 4 of 11 residents (Resident #134, Resident #46, Resident #22, and Resident #58)	F164	Croasdaile Villages response to this 2567 does not denote agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate or that a deficiency existed. We are filing the POC to meet the requirements established by state and federal law. Croasdaile Village reserves the right to refute any deficiencies on this 2567 through the informal dispute resolution or formal appeal process. The facility will provide privacy of confidential records during medication administration for residents #134, #46, #22, and #58 The facility will provide privacy of confidential records during medication administration for all residents requiring medication in the facility. All MAR (Medication Administration Record) binders will have an extra non-see through page divider added to each MAR binder for use during medication administration.	6/30/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: administrator | (X6) DATE: 6/29/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 Findings included: 1. An open Medication Administration Record (MAR) was observed on top of a medication cart during a continuous observation of a medication cart located in the hallway in the second floor nursing station on 06/05/2012 from 3:43 to 3:45 PM, The MAR for Resident #134 was left open with no cover and unattended during the observation. The medication cart was being used by LPN #3. LPN #3 reentered the hallway from a room with a closed door and returned to the cart at 3:45 PM. During the observation, visitors were observed walking by the medication cart. On 06/05/2012 at 4:02 PM, LPN #3 poured medications for Resident #134 (Room 202) at the resident's door in the hallway. LPN #3 then entered the resident's room, stood beside the resident's bed and administered the medications. During the medication administration, the resident's MAR was left open with no cover on top of the medication cart in the hallway. The medication cart was not in view of the LPN during the medication administration. The Director of Nursing was interviewed on 06/06/2012 at 11:10AM. She reported there was no facility policy that addressed privacy related to the MAR, but it was the expectation staff covered residents' confidential information or close the MAR when away from the medication cart. 2. On 06/05/2012 at 4:13PM, LPN #3 poured medications for Resident #46 (Room 213) at the resident's door in the hallway. LPN #3 then entered the resident's room, stood beside the	F 164	All license staff with medication administration responsibilities will be re educated by the Staff Development Coordinator regarding maintaining privacy of confidential resident records during medication administration. The Director of Nursing or staff development Coordinator will randomly observe staff during medication administration at least 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then once a week for 4 weeks, to ensure privacy of confidential records is maintained during medication administration. All observations will be documented on a facility quality assurance monitoring tool. Any negative findings will be corrected at this time. All findings will be integrated into the facility quality assurance program and be evaluated for effectiveness. Any further training or monitoring needed will be discussed at that time and will continued through the quality assessment and assurance process. The Quality Assurance Committee (QA) to include the Administrator, DON, Pharmacy Consultant, and Medical Director, will review the audit results and follow up on any action plans during the QA meetings. Any item on the action plan will be completed to ensure continued compliance.	6/30/12 6/30/12

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F 164	Continued From page 2 resident's bed and administered the medications. During the medication administration, the resident's MAR was left open on top of the medication cart in the hallway. The medication cart was not in view of the LPN during the medication administration. The LPN exited the resident's room at 4:15PM, reported he was going to wash his hands and went into a closed room on the hallway, leaving the open MAR on top of the medication cart. He reentered the hallway approximately 45 seconds later and returned to the medication cart. The Director of Nursing was interviewed on 06/06/2012 at 11:10AM. She reported there was no facility policy that addressed privacy related to the MAR, but it was the expectation staff covered residents' confidential information or close the MAR when away from the medication cart.	F 164		
	3. On 6/6/2012 at 08:40 am, a continuous observation was made of LPN #4 preparing medications for resident #22 in the hallway on the first floor. LPN # 4 left the medication cart unattended and not in her view for 2 minutes, left the MAR open, did not cover the residents personal information, and delivered medications to the resident. While the cart was unattended and the MAR left open exposing the residents personal information, an maintenance worker had been fixing a light in the hallway at the cart site. On 6/6/2012 at 11:10 am, an interview with the Director of Nursing reported there was no facility policy that addressed privacy related to the MAR, but it was the expectation staff covered resident's confidential information or close the MAR when			

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F 164	Continued From page 3 away from the medication cart. On 6/6/2012 at 11:35 am an interview with Nurse #4 indicated that it is the resident's right for privacy. The nurse indicated she had been trained to close the MAR or cover the personal information of the resident when she had walked away from the medication cart. 4. On 6/6/2012 at 09:06 am, LPN #4, during a continous observation, had prepared medications in the first floor hallway for resident #58, left the MAR open and did not cover the residents personal information. Nurse #4 walked away from the medication cart into the residents room with the medication cart not in her view. The whole time the nurse was away from the cart with the residents personal information exposed the maintanence worker was present and able to view the MAR. On 6/6/2012 at 11:10 am, an interview with the Director of Nursing reported there was no facility policy that addressed privacy related to the MAR, but it was the expectation staff covered resident's confidential information or close the MAR when away from the medication cart. On 6/6/2012 at 11:35 am an interview with Nurse #4 indicated that it is the resident's right for privacy. The nurse indicated she had been trained to close the MAR or cover the personal information of the resident when she had walked away from the medication cart.	F 164		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive	F 328	The facility will: 1) change oxygen tubing per facility protocol, 2) ensure container with distilled water is not empty per facility protocol, and 3) ensure oxygen tank is secured in the reservoir per facility protocol for Resident #18.	6/30/12

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F 328	Continued From page 4 proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to change the oxygen tubing, keep the humidifier/water bottle filled, and secure the oxygen tank in the reservoir per protocol for 1 of 1 resident (resident #18). 1. Resident # 18 was admitted to the facility on 3/27/2012 with cumulative diagnosis of congested heart failure, pacemaker, cardiovascular disease, hypothyroidism, rheumatoid arthritis, chronic renal failure, and chronic obstructive pulmonary disease with use of oxygen. On 6/4/2012 at 3:50 pm an observation of the named resident ' s oxygen tubing had date of last change on the tubing of 5/16/2012 (a Wednesday). Per the facility protocol oxygen tubing was to be changed every Tuesday on the night shift (11 pm to 7 am) by the nurse. Last date of change was 19 days past due. Observations on 6/5/2012 at 10:30 am, 6/5/2012 at 1:00 pm, 6/5/2012 at 5:00 pm revealed oxygen tubing with date of change of 5/16/2012. Review of the resident medical record had an order since admission for nasal Cannula oxygen for 3 Liters via mask or nasal cannula that had	F 328	The facility will change oxygen tubing for all residents using oxygen once a week. The facility will ensure all residents with orders to receive humidified oxygen will have distilled water container with enough water so when the oxygen flows through the container bubbles are visible. The container with the distilled water will be dated with the date the container was opened and changed within seven days or more frequently as needed. The facility will ensure all oxygen cylinders are secured in the reservoir when in resident use or secured in utility closet when not in use. All licensed staff will be re educated by the Staff development Coordinator regarding facility Infection Control policies and procedures relating to: the use of humidified oxygen, and 3) the facility policy regarding Storage of oxygen cylinders.	6/30/12 6/30/12 6/30/12

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F 328	Continued From page 5 been signed for each shift by a nurse. Review of the facility staff inservice record dated 10/27/2011 had informed the staff that oxygen tubing ' s were to be changed weekly during the night shift with the staff to initial and date the tubing. Review of the facility oxygen therapy and storage policy dated 1/1/2012 indicated the oxygen tubing ' s and cannulas are to be replaced one time a week on the night shift (11 pm to 7 am) with the date, time and initials of the nurse who changed them. Review of the 11 pm-7 am nursing duties list dated 3/22/2012 included that the nurse was responsible to change and to date the oxygen tubing every Tuesday night. Review of the facility March 2012 staff meeting minutes indicated that the oxygen tubing had been reported as not being changed or dated weekly per protocol. On 6/5/2012 at 1:00 pm an interview with the named resident indicated she wore the oxygen at all times. On 6/5/2012 at 4:50 pm an interview with Nurse #6 indicated that oxygen tubing was to be changed weekly on the night shift (11 pm-7 am) by the nurse. On 6/5/2012 at 5:00 pm an interview with the Director of Nursing (DON) indicated the oxygen tubing was to be changed every Tuesday on the night shift by the nurse. The DON indicated her expectation was that it was done by the nurse. She indicated her expectation was for any nurse to change the tubing if it was outdated. On 6/6/2012 at 09:00 am an observation was made of the named resident ' s oxygen tubing with date of change of 6-5-2012. On 6/7/2012 at 11:24 am an interview with Nurse	F 328	The director of nursing and /or staff development coordinator will make random observations 3 times a week (to include all oxygen in use) for 2 weeks 3 days a week for 8 weeks to ensure: 1) all oxygen tubing is changed once a week and labeled with the date it was changed, 2) that all oxygen concentrators providing humidified oxygen has a container with an adequate amount of distilled water to deliver the humidified oxygen, and 3) that all oxygen cylinders are stored and secured properly. All observations will be documented on a facility quality assurance monitoring tool. Any negative findings will be corrected at that time as well as documented. All findings will be integrated into the facility Quality assurance program and be evaluated for effectiveness. Any further training or monitoring needed will be discussed at that time and continue through the quality assessment and assurance process.	

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F 328	Continued From page 6 #1 indicated all nurses are responsible to make sure a resident ' s oxygen tubing was labeled, she indicated the night shift nurse had been responsible to change the oxygen tubing weekly. 2. Resident # 18 was admitted to the facility on 3/27/2012 with cumulative diagnosis of congested heart failure, pacemaker, cardiovascular disease, hypothyroidism, rheumatoid arthritis, chronic renal failure, and chronic obstructive pulmonary disease with use of oxygen. On 6/4/2012 at 3:50 pm an observation of the named resident ' s oxygen humidifier/water bottle on the concentrator was empty with no date on it. The named resident had nasal cannula oxygen at 3 liters in place. Per the facility protocol oxygen humidifier/water bottles was to be changed every Tuesday on the night shift (11 pm to 7 am) by the nurse. Observations on 6/5/2012 at 10:30 am, 6/5/2012 at 1:00 pm, 6/5/2012 at 5:00 pm revealed the oxygen humidifier/water bottle was empty. Review of the resident medical record had an order since admission for nasal Cannula oxygen for 3 Liters via mask or nasal cannula that had been signed for each shift by a nurse. Review of the facility staff inservice record dated 10/27/2011 had informed the staff that the oxygen humidifier/water bottles were to be changed weekly during the night shift with the staff to initial and date it. Review of the facility oxygen therapy and storage policy dated 1/1/2012 indicated the oxygen humidifier/water bottles are to be replaced weekly on the night shift (11 pm to 7 am). The oxygen administration policy indicated for the nurse to be sure the humidifier/water bottle water level was high enough that the water bubbles as oxygen flows through, to humidify the oxygen. The policy	F 328	The Quality Assurance Committee (QA) to include the Administrator, DON, Pharmacy Consultant, and Medical Director, will review the audit results and follow up on any action plans during the QA meetings. Any item on the action plan will be completed to ensure continued compliance.	6/30/12

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F 328	Continued From page 7 also indicated for the staff to periodically re-check the water level in the humidifying jar. Review of the 11 pm-7 am nursing duties list dated 3/22/2012 included that the nurse was responsible to change the oxygen concentrator humidifier/water bottles every Tuesday night. On 6/5/2012 at 4:50 pm an interview with Nurse #6 indicated that oxygen concentrator humidifier/water bottles was to be checked daily on the night shift (11 pm-7 am) by the nurse. On 6/5/2012 at 5:00 pm an interview with the Director of Nursing (DON) indicated the oxygen concentrator humidifier/water bottles was to be changed every Tuesday on the night shift by the nurse. The DON indicated her expectation was that it was done by any nurse. She indicated her expectation was for any nurse to change the humidifier/water bottle if it was dry. On 6/6/2012 at 09:00 am an observation was made of the named resident ' s oxygen humidifier/water bottle was full with date of change of 6-5-2012. On 6/7/2012 at 11:24 am an interview with Nurse #1 indicated all nurses are responsible to make sure a resident ' s oxygen humidifier/water bottle was labeled and not dry. Nurse #1 indicated any nurse had been responsible to make sure the humidifier/water bottle had not been dry. 3.2. Resident # 18 was admitted to the facility on 3/27/2012 with cumulative diagnosis of congested heart failure, pacemaker, cardiovascular disease, hypothyroidism, rheumatoid arthritis, chronic renal failure, and chronic obstructive pulmonary disease with use of oxygen. On 6/4/2012 at 3:50 pm an observation of the named resident ' s oxygen cylinder tank was not in the reservoir per protocol for safety. The cylinder tank was free standing with the reservoir	F 328		

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F 328	Continued From page 8 across the room. Observations on 6/5/2012 at 10:30 am, 6/5/2012 at 1:00 pm, 6/5/2012 at 5:00 pm revealed the oxygen cylinder tank remained free standing with the reservoir across the room. Review of the resident medical record had an order since admission for nasal Cannula oxygen for 3 Liters via mask or nasal cannula that had been signed for each shift by a nurse. Review of the facility oxygen therapy and storage policy dated 1/1/2012 indicated the oxygen cylinder tanks should always be chained tightly in reservoir, on transport, and when in the oxygen room. Review of the facility oxygen administration policy indicated that the portable oxygen cylinder tanks should be strapped to the stand/reservoir. On 6/5/2012 at 5:00 pm an interview with the Director of Nursing (DON) indicated the oxygen cylinder tanks were to be in a cylinder holder/reservoir at all times. On 6/6/2012 at 11:25 am an interview with the central supply clerk indicated that all oxygen cylinder tanks were to be in the reservoir at all times. On 6/6/2012 at 11:25 am an observation was made of the named resident ' s oxygen tank with the DON free standing with the oxygen cylinder reservoir across the room. The DON stated " It should be in the reservoir " . The DON was observed to place the oxygen cylinder tank into the reservoir.	F 328		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332	The facility will maintain a medication error rate of less than 5 percent. The order for Allegra 60mg was discontinued on 5/5/12 for Resident #15. A doctor's order was obtained for 1 Cap Eye vitamins and Spironalactone on 5/6/12 for Resident # 15.	

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F 332	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to maintain a medication error rate of less than 5 percent. Findings included: 1. Record review indicated Resident #15 was readmitted to the facility on 12/11/2011 following a hospital stay. The resident's diagnoses included Glaucoma. During a medication administration observation on 06/06/2012 at 9:30 AM, LPN (Licensed Practical Nurse) #2 placed medications into a medication cup for Resident #15 that included: I Cap Eye Vitamin one tablet, Spironalactone 25 mg 1 tablet and Allegra 60 mg 1 tablet. The LPN entered the resident's room, stood beside the resident's bed and administered all medications orally to the resident. Review and reconciliation of physician orders indicated Allegra 60 mg was ordered on 12/11/2011 and discontinued on 12/22/2011. There were no further orders in the record for Allegra. Allegra was not recorded on the June 2012 MAR. There were no orders in the resident's record for I Cap Eye Vitamins or Spironalactone and neither medication was on the June 2012 MAR. Inspecion of the 3 medication containers revealed the resident's name on each bottle/package. In an interview with LPN #2 on 06/06/2012 at 10:00AM, she reported she did not look at the	F 332	All MARS were compared to the Physician Orders for accuracy. Any discrepancy was verified by the doctor and corrected on the MAR at that time. Three different nurses verified each order was written as ordered on the MAR. All license staff with medication administration responsibilities will be re educate regarding medication administration policies and procedures. The re education will be done by the Pharmacist and /or Director of Nursing. The Director of Nursing or staff development Coordinator will randomly observe at least one complete med pass 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then once a week for 4 weeks to ensure the licensed nurse is reading the MAR and making sure the correct medicine and correct dosage are being administered during medication administration. All observations will be documented on a faculty quality assurance monitoring tool. Any negative findings will be corrected at this time. All findings will be integrated into the facility quality assurance program and be evaluated for effectiveness. Any further training or monitoring needed will be discussed at that time and will be	6/30/12 6/30/12 6/30/12

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F 332	Continued From page 10 MAR closely enough while pouring the medications and should have. She indicated the resident had been on the medications in the past and she thought the resident was still on the medications. In an interview with the Director of Nursing on 06/06/2012 at 11:10AM, she indicated the expectation was staff who administered medications should follow the MAR when giving medications. 2. Resident # 62 was admitted to the facility on 9/27/2011 with cumulative diagnosis of atrial flutter, congested heart failure, diabetes mellitus, cardiovascular disease, hypertension, dementia, hypothyroidism, and cardio vascular accident. On 6/6/2012 at 10:05 am during a medication administration, Nurse #5 prepared the medications for resident #62, had picked up the medications and had started to walk away from the medication cart toward the resident ' s room. When stopped and asked how much Peridex the resident was to receive, the nurse returned to the medication cart and put the medication back down and responded with " well it does not say how much to give ". The nurse had poured 30 milliliters. When pointed out to Nurse #5 the MAR (medication administration record) had the order as Peridex 12 % swish and spit 5 milliliters by mouth four times daily for dry mouth, Nurse #5 was observed to remove 25 milliliters of the Peridex from the medicine cup. The nurse was observed to give only the prescribed amount of Peridex.	F 332	Continued through the quality assessment and assurance process. The Quality Assurance Committee (QA) to include the Administrator, DON, Pharmacy Consultant, and Medical Director, will review the audit results and follow up on any action plans during the QA meetings. Any item on the action plan will be completed to ensure continued compliance.	6/30/12

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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 332	Continued From page 11 On 6/6/2012 at 11:10 am, an interview with the Director of Nursing indicated her expectation of the medication nurses was for them to use the MAR as a guide to give medications and that the nurses should have looked at and read the MAR orders as written when they prepared the medications. On 6/6/2012 at 3:00 pm an interview with Nurse #5 indicated with a medication error she would have called the physician and the family of the resident to report the error and filled out a medication error report sheet. Nurse #5 indicated the five rights of medication administration were the right name of the resident, the right time of administration of the medication, the right route for medication to be administered, the right medication to be administered and the right amount of the medication to be administered. The nurse stated she was nervous and should have read the MAR.	F 332		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and	F 371	The facility will ensure all opened containers of food are labeled with the date the container was opened. The facility will ensure that all dietary staff wash their hands with soap and water before handling clean utensils and/or dishes. All dietary staff will be re educated by the Staff Development Coordinator regarding the facility policy on food opening and storage.	6/7/12 6/30/12 6/30/12

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F 371	Continued From page 12 record review, the facility failed to store food under sanitary conditions by not dating opened containers of food, and by failing to ensure proper hand washing by the dish washer while handling dirty and clean dishes. The findings include: 1. The facility policy on food opening and storage states, " Expiration dates printed by the manufacturer apply until the product is opened. Once opened, use these time limits unless the manufacturer ' s date is earlier. The day of opening/preparation counts as day 1. " The policy indicated for commercially prepared salads the expiration date is 4 days. For salad dressings and mayonnaise the expiration date is 30 days, for relish the expiration date is 60 days, and for brownie mix the expiration date is 6 months. On an initial tour of the facility kitchen on 6/4/2012 at 10:30 AM, in the main kitchen walk-in refrigerator, there were containers of opened mayonnaise, sweet relish, vinaigrette dressing, and pimento cheese that had no date. On 6/4/2012 at 10:45 AM in the dry storage room, there was an opened box of brownie mix with no date. In an interview on 6/4/2012 at 10:45 AM, the executive chef stated that the staff knows that all containers must be dated when opened. On a tour on 6/4/2012 at 4:15 PM, the opened containers of pimento cheese, sweet relish, vinaigrette dressing, and mayonnaise were observed in the walk in refrigerator in the main kitchen. These opened containers still were not dated.	F 371	All dietary staff will be re educated by the Staff Development coordinator regarding the facility policy on hand hygiene. All dietary staff will do return demonstration of hand washing to ensure procedure is performed correctly. The dietary/kitchen manager will randomly check all food storage areas to ensure all open containers of food are labeled with the date the container was opened, as well as make random observations of dietary staff while washing and storing utensils and dishes 3 times a week for 4 weeks, then 3 times a week for 8 weeks. Any findings will be documented on a facility quality assurance monitoring tool and integrated into the facility quality assurance program and be evaluated for effectiveness. Any further monitoring will be decided at that time and continued through the quality assurance and assessment program. The Quality Assurance Committee (QA) to include The Administrator, DON, Pharmacy Consultant, and Medical Director, will review the audit results and follow up on any action plans during the QA meetings. Any item on the action plan will be completed to ensure continued compliance.	6/30/12 6/30/12 6/30/12

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F 371	Continued From page 13 2. The facility policy on hand hygiene dated 11/09, states: " All employees associated with the handling of food shall wash hands. Hands are washed with soap and water at the following times: Before handling food or clean utensils/dishes/equipment. After handling soiled silverware. After any other activity that may contaminate the hands. " The procedure policy states " Use sinks designated for hand washing. " On 6/7/2012 at 11:20 AM during an observation of the dish machine in the main kitchen, the dish washer was observed moving from the dirty area, where he was rinsing and loading trays of dirty dishes, to the clean area where dishes had come out of the dish machine, and he stacked these clean dishes to dry. He did not wash his hands between the two areas. His hands were observed to be wet, and he wiped them on his apron before touching the clean dishes. In an interview on 6/72012 at 12:00 noon, the assistant director of dining stated that sometimes there are two people working the dish machine, and sometimes only one. The assistant director of dining stated that the expectation would be for the dish washer to wash his hands with soap and water for at least thirty seconds under hot water, as he was taught. In an interview with the dish washer on 6/7/2012 at 12:20 PM, the dish washer stated that he rinses his hands with the sprayer at the dirty dish sink. He demonstrated spraying his hands off at the sink where he was rinsing the dirty dishes.	F 371		

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F 371	Continued From page 14 In an interview on 6/8/2012 at 11:30 AM, the assistant director of dining stated that hands would be washed with soap and hot water per facility policy.	F 371		

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	345501	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/20/2012

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K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation on Wednesday 6/20/12 at approximately 12:30 PM onward the following was noted. 1) The staff when questioned about the procedures to unlock all the mag lock door from one location were not familiar with the master override switch located at the nurse station. 42 CFR 483.70(a)	K 038	Croasdaile Villages response to this 2567 does not denote agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate or that a deficiency existed. We are filing the POC to meet the requirements established by state and federal law. Croasdaile Village reserves the right to refute any deficiencies on this 2567 through the informal dispute resolution or formal appeal process. K 038 **Corrective Action:** Facility staff will be in serviced on the location of the master override switch at the nurse station.	7/18/2012
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: Based on observation on Wednesday 6/20/12 at	K 052	**Identifying Life safety Issues:** Facility staff will be in serviced on the location of the master override switch at the nurse station. **Systematic Changes:** Facility staff will be in serviced upon new hire and will be in serviced and questioned monthly during the monthly fire drills about the location of the master override switch.	7/18/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7-3-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 052	Continued From page 1 approximately 12:30 PM onward the following was noted. 1) When the Fire Alarm Control Panel (FACP) was check while the emergency generator was running the FACP lost all power when the battery back-up power was removed. 42 CFR 483.70(a)	K 052	K 038 **Monitored:** The Safety and Security Director or designee will document the monthly in service on a facility monitoring tool. Any negative findings will be corrected at this time.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Wednesday 6/20/12 at approximately 12:30 PM onward the following was noted. 1) The tamper alarms for the sprinkler system located in the valve pit outside did not activate an alarm when the valve was closed. 42 CFR 483.70(a)	K 056	All findings will be integrated into the facility quality assurance program and evaluated for effectiveness. Any further training or monitoring needed will be discussed at that time and will continue through the quality assessment and assurance process. The Quality Assurance Committee (QA) to include the Administrator, DON, Pharmacy Consultant, and Medical Director, will review the audit results and follow up on any action plans during the QA meetings.	

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K 052	Continued From page 1 approximately 12:30 PM onward the following was noted. 1) When the Fire Alarm Control Panel (FACP) was check while the emergency generator was running the FACP lost all power when the battery back-up power was removed. 42 CFR 483.70(a)	K 052	**K 052** **Corrective action:** Maintenance Department contracted with simplex Grinnell to repair the Fire Alarm Control Panel. Simplex Grinnell replaced the power supply.	6/25/12
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Wednesday 6/20/12 at approximately 12:30 PM onward the following was noted. 1) The tamper alarms for the sprinkler system located in the valve pit outside did not activate an alarm when the valve was closed. 42 CFR 483.70(a)	K 056	**Identifying Life Safety Issues:** Simplex Grinnell tested the Fire alarm Control Panel (FACP) while the emergency generator was running and the battery backup was removed. The FACP continued to operate normally. **Systematic Changes:** The FACP will be tested during the monthly generator tests with the battery back-up power removed to ensure the FACP operates properly.	6/25/12

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K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Wednesday 6/20/12 at approximately 12:30 PM onward the following was noted. 1) The tamper alarms for the sprinkler system located in the valve pit outside did not activate an alarm when the valve was closed. 42 CFR 483.70(a)	K 056		

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