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	345501	A. BUILDING _____ B. WING _____	C 07/09/2015

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CROASDAILE VILLAGE	**2600 CROASDAILE FARM DURHAM, NC 27705**

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F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview and staff interviews the facility failed to provide a right hand palm protector to 1 of 2 sampled residents (Resident #3) for contracture management. Findings included: Resident #3 was admitted to the facility on 04/17/14. The resident's diagnosis included altered mental status, chronic obstructive pulmonary disease (COPD), fracture of malleolus, and chronic demyelinating polyneuropathy. Physician's Telephone Order dated 05/8/14 revealed to discharge skilled Occupational Therapy (OT) services, ordered weighted utensils, and a right palm protector. Review of the OT weekly treatment plan dated 05/8/14 under self-reliance task addressed and skilled intervention listed: Utensils and a right palm protector. Resident #3's Quarterly Minimum Data Set (MDS) dated 04/15/15 revealed Resident #3 had short and long term memory problems and was severely impaired in cognitive skills for daily	F 318	Croasdaile Village acknowledges receipt of the Statement of Deficiencies and purposes of 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 6-9, 2015 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 the Statement of deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative of legal procedures. #1 Corrective action for the affected	7/31/15

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

Electronically Signed | 07/30/2015

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F 318	Continued From page 1 decision making. Resident #3 was dependent on staff for eating, transfers, dressing, locomotion, bathing, and personal hygiene. Resident #3 was coded for bilaterally upper extremity impairment. Review of Resident's Care Plan dated 05/14/15 revealed self-care deficit, requires assistance with Activities for Daily Living (ADLS), and for Physical Therapy (PT)/ Occupational Therapy (OT)/ Speech Therapy (ST) to evaluate and treat as indicated. Review of the Certified Nurse Assistant (CNA)'s most recent care tracker dated 08/5/14 revealed no palm protector listed under assistive devices, only glasses. Review of the July 2015 Treatment Record showed an order dated 05/8/14 for Resident #3 to have a right palm protector. Review of Resident #3's current medications listed for the month of July 2015: right palm protector, Restorative Nursing Aide (RNA) to assist resident with Passive Range of Motion (PROM) exercises to bilateral upper and lower extremity 1 set of 10 repetitions 3 times per week as tolerated. The Treatment Record showed an order dated 07/1/15 for Resident #3 to have a right palm protector. The Treatment Record showed an initial and discontinued date of 07/9/15 next to the resident to have right palm protector. During an interview with CNA #2 on 07/9/15 at 10:10 AM, revealed that she did AM care for Resident #3, which included: bathing, dressing, oral care, applying hose/socks/and shoes, Hoyer	F 318	resident: Occupational Therapy began seeing this resident on 7/9/15 per physician orders for contracture management and equipment management. On 7/22/15 resident received orders to wear palm splint for 6 hours daily during the morning from 7am-3:30pm. #2: Corrective action for all resident's affected: A complete chart audit was completed for residents with adaptive equipment to ensure that all adaptive equipment was in place for residents per orders. No other areas of concern were identified. Education was provided for all nursing team members on the implementation and follow thru with adaptive devices per physician orders. #3: Prevention Measures/Systematic Changes: Monthly audits will be conducted by DON/designee to ensure continued compliance with physician orders for adaptive devices. Education was provided for all nursing team members on the implementation and follow thru with adaptive devices per physician orders. #4: Method of Monitoring: DON/Designee will complete audits of adaptive equipment and areas of concern	

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F 318	Continued From page 2 lift to chair, oxygen placement via nasal cannula if oxygen was low, and feeding. The CNA said Resident #3 never had a palm protector. In an observation on 07/7/15 at 5:00 PM Resident #3 was sitting up in bed resting. She was dressed, had hand tremors, and her right hand was contracted with no palm protector. In an observation on 07/8/15 at 3:30 PM Resident #3 was sitting in a chair in the common area watching TV. Resident #3 had no palm protector on her right hand. In an observation on 07/9/15 at 10:30 AM resident #3 was sitting in the common area in her wheelchair watching TV. She had no palm protector on her right hand. During an interview and Resident #3 room tour with CNA #2 on 07/9/15 at 10:10 AM, revealed that CNA #2 was not able to find or produce a right palm protector for Resident #3. The CNA said that she never saw a hand protector for Resident #3. An interview with CNA #2 on 07/9/15 at 2:47 PM revealed that for the last 4 months (since she had been working with Resident #3), Resident #3 never had never a palm protector, and that it was not listed on their CNA care tracker. An interview with Nurse #2 on 07/9/15 at 2:50 PM revealed that since Resident #3 had an order for a palm splint, she should have had one. The nurse said, since it was listed on the Medicine Administration Record (MAR) the nurses should have checked the MAR and the resident to make sure the aides had put the palm protector on the	F 318	will be immediately followed up on. Audits will be submitted monthly to the QAPI committee during scheduled meetings. QAPI audits will be completed monthly for 6 months; additional audits will be completed based upon level of compliance.	

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F 318	Continued From page 3 resident. An interview with Rehabilitation Director on 07/9/15 at 10:15 AM confirmed Resident #3 had a physician's order dated 05/8/15 for a right palm protector, but did not have one. An interview with the Assistant Director of Nursing (ADON) on 07/9/15 at 11:36 AM revealed that Resident #3 should have had a palm protector on per physician's order. He said Resident #3 had no documentation in the CNA care tracker for a palm protector, and that aide documentation should have been there. In an interview on 07/9/15 at 12:44 PM Resident #3 said she never had a right palm protector. During an interview with the DON on 07/9/15 at 12:53 PM, revealed it was her expectation that a palm protector should have been provided to Resident #3 as ordered.	F 318		
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, physician and staff interviews, the facility did not administer a cardiac medication as ordered for 1 of 1 sampled residents (Resident #24) whose medications were reviewed. Findings included: Resident #24 was admitted to the facility on	F 333	Past noncompliance: no plan of correction required.	7/24/15

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02/26/15 and discharged to the hospital on 05/17/15. Cumulative diagnoses included congestive heart failure, atrial fibrillation, renal insufficiency and hypothyroidism.

According to the admission orders of 02/26/15, Resident #24 ' s medications included Diltiazem (a medication used for certain cardiac arrhythmias) 180 milligrams twice daily.

The February 2015 medication administration record (MAR) for Resident #24 was reviewed. It was noted that Diltiazem Hydrochloride (HCL) 180 milligrams was administered twice daily as of 02/26/15 for atrial fibrillation.

A physician ' s note of 02/27/15 noted Resident #24 was admitted from her apartment because of right hip pain that had made movement in and out of bed difficult. Her medications included Diltiazem. Diagnoses listed included atrial fibrillation.

The Admission Minimum Data Set (MDS) assessment of 03/09/15 noted impaired decision making skills. Resident #24 needed extensive to total assistance with activities of daily living.

The handwritten physician ' s orders for March 2015 for Resident #24 included Diltiazem HCL 180 milligrams twice daily.

According to the March 2015 medication administration record for Resident #24, Diltiazem 180 milligrams was administered twice daily for the entire month.

There was no physician ' s order for Diltiazem noted on the April 2015 MAR for Resident #24.

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F 333	Continued From page 5 Nurse #2 had signed the physician order sheet indicating the April 2015 MAR had been checked for accuracy on 03/26/15. There were no other signatures noted on the order sheet. Resident #24 did not receive Diltiazem from April 1, 2015 through April 7, 2015. Nurse #2 was interviewed on 07/09/15 at 11:50 AM. She stated she was familiar with Resident #24 and had administered medications to her until she was transferred to a different floor and was aware that she took Diltiazem. Nurse #2 explained that the month end changeover process started a few days before the new month started. She reported the new MAR ' s were distributed to the different nurses ' stations a few days prior to month end. She stated there was a schedule posted at each nurse ' s station noting which nurse was responsible for the first accuracy check and the second accuracy check for the new MARs. She stated she was assigned the first accuracy check for the changeover from the March 2015 MAR to the April 2015 MAR. Nurse #2 reported when she checked Resident #24 ' s MARs and the physician ' s orders she missed the Diltiazem for some reason. Nurse #2 stated prior to this incident only 2 nurses were assigned to check the MARs for accuracy during changeover but that had been changed. Nurse #2 commented that Diltiazem (Cardizem) was an essential medication given for arrhythmias and if it wasn ' t given as ordered the resident could develop shortness of breath and heart fluttering. A nurse note of 04/02/15 at 2:15 PM indicated Resident #24 was transferred to a room on the first floor with all of her medications and her belongings.	F 333		

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A nurse note of 04/05/15 at 3:10 PM noted Resident #24 was having shortness of breath on exertion. The writer asked her if she could notify the physician and Resident #24 responded she would prefer not to start on any medication now and she would think about it.

A nurse note of 04/07/15 at 4:58 AM written by Nurse #3 noted that Resident #24 was sent to the emergency room for shortness of breath. Her vital signs were noted as follows: temperature of 99.3 degrees Fahrenheit, pulse of 119, respirations of 22 and blood presssure of 132/86. Nurse #3 also noted Resident #24 left at approximately 4:55 AM after intravenous medications were given for atrial fibrillation by the emergency medical technicians. Her family as well as the physician was notified.

Nurse #3 was interviewed via telephone on 07/09/15 at 4:08 PM. She stated on the night Resident #24 was sent to the emergency room, she had complained of shortness of breath and she had gone in to check on her. She stated the air conditioner was off. She stated she raised the head of her bed and she seemed to be okay for a while but then she started having a really difficult time breathing. Nurse #3 stated she obtained the order to send Resident #24 out to be evaluated and sent a copy of her current MAR with her. She commented that shortly after Resident #24 went out to the emergency room she received a telephone call from her family inquiring about her Diltiazem and asking if it had been discontinued prior to her being sent out. Nurse #3 stated she looked over Resident #24 ' s April 2015 MAR and noticed there was no mention of the Diltiazem. She stated she reported to the family that it must have been a mishap during the monthly end of

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the month changeover. Nurse #3 stated Resident #24 had been moved from one floor to another shortly before being sent out to the emergency room on 04/07/15. She reported the nurses would not have known that a medication was missing as they were given the current MAR from the transferring floor nurse. Nurse #3 also reported when residents were moved from one floor to another their medications were sent with them along with the current MAR. She reported prior to this incident only 2 nurses were checking the new MAR ' s for accuracy. She reported the facility had changed the process for checking month end MAR ' s from two nurses checking for accuracy to three nurses checking to prevent future occurrences. Nurse #3 reported that it was third shift nurses ' responsibility to check the ending month ' s MAR against the upcoming month ' s MAR for errors or missing medications. She stated the new MARs were distributed about a week before the new month started to give staff time to check for accuracy as well as checking for any new telephone orders received since the new MAR was distributed to the floor nurses. She stated Resident #24 ' s Diltiazem was overlooked during changeover.

A physician ' s telephone order of 04/07/15 noted to send Resident #24 to the emergency room for complaints of shortness of breath per request.

Hospital records for Resident #24 ' s admission of 04/07/15 were reviewed. A general medicine history and physical of 04/07/15 noted Resident #24 had a history of hypertension, mild systolic dysfunction and paroxysmal atrial fibrillation. It noted that Resident #24 presented to the emergency room with a 3 day history of shortness of breath. It was also documented that Resident

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#24 had longstanding atrial fibrillation and was previously on 180 milligrams of Diltiazem CD but had been off the medication for the past week for unknown reasons. She developed atrial fibrillation with rapid ventricular rate (RVR) with a heart rate in the 150 ' s and was given 2 doses of intravenous Diltiazem with improvement in her heart rate to the 110 ' s by emergency medical technicians. Upon arrival to the emergency room, an electrocardiogram showed atrial fibrillation with a heart rate of 121.

The hospital admission note of 04/08/15 indicated Resident #24 was tachypneic (rapid respirations) with a heart rate of 110 - 120 beats per minute with a Diltiazem drip infusing upon arrival. It was noted that Resident #24 was followed by cardiology for longstanding paroxysmal atrial fibrillation since 2006. It was also documented that etiologies were discussed for her recurrent atrial fibrillation with RVR and it appeared that she had not been on her prescribed Diltiazem CD 180 milligrams for at least the past week for unclear reasons.

According to hospitalization records for Resident #24 ' s 04/07/15 admission, it was documented that the physical therapy department had completed an initial evaluation on 04/09/15. It was noted that the reason for admission was persistent atrial fibrillation and mild systolic dysfunction with sub-acute worsening dyspnea after not receiving her Diltiazem for the past week.

Upon Resident #24 ' s re-admission to the facility on 04/16/15, the April 2015 physician's order summary sheet of 04/16/15 noted Cardizem (used for Diltiazem) CD 300 milligrams daily for

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F 333	Continued From page 9 atrial fibrillation. A physician ' s note of 04/16/15 indicated Resident #24 was sent to the emergency department due to dyspnea and was found to be in atrial fibrillation with rapid ventricular rate (RVR). It was noted that Resident #24 required a Diltiazem drip and eventually stabilized. The physician also noted the atrial fibrillation with RVR was now rate controlled and to continue Diltiazem ER 300 milligrams daily. Resident #24 ' s initial care plan of 04/16/15 identified cardiac problems which included atrial fibrillation. Approaches included to monitor her heart rate and endurance. The comprehensive care plan, last reviewed on 04/22/15, noted she had self-care deficit and required assistance with activities of daily living. Approaches included to administer medications as ordered. Another Admission MDS assessment of 04/23/15 for Resident #24 ' s admission date of 04/16/15 noted she was mildly cognitively impaired. She required extensive to total assistance with activities of daily living. The Care Area Assessment detail (CAA) for this MDS noted she triggered in 12 areas including cognitive loss. The cognitive loss CAA noted she had been admitted with diagnoses including dyspnea and atrial fibrillation. The April 2015 MAR which was completed for Resident #24 ' s re-admission noted she had received Cardizem (used for Diltiazem) CD 300 milligrams from 04/16/15 through 04/30/15. Resident #24 ' s physician was interviewed on 07/08/15 at 4:00 PM. She reported that Resident	F 333		

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#24 had a history of atrial fibrillation. She stated Diltiazem was a longer acting drug and could take longer to clear from one ' s system once they stopped taking the medication. She reported being aware of the issue with Resident #24 not receiving Diltiazem. The physician stated she was sent out to the emergency room on 04/07/15. She stated while she was in the emergency room it was discovered that Diltiazem was not listed on the MAR that was sent with her. The physician reported that her family had telephoned the facility asking about the Diltiazem. She reported this to be an unfortunate situation with this particular medication being overlooked during month end changeover. She also reported it should not have happened. The physician stated missing several doses of Diltiazem probably contributed to her decompensation. She also reported that the facility had realized there was a problem with the changeover and changes were made as well as additional monitoring was put into place.

The Director of Nurses (DON) and the Administrator were interviewed on 07/09/15 at 10:00 AM. The DON stated Resident #24 was sent out during third shift on 04/07/15. She stated she was told by nursing staff that Resident #24 had become short of breath earlier that day and was sent out to the emergency room. She stated a few hours later a family member telephoned the facility to clarify her medications as she didn ' t see Diltiazem listed on the MAR that was sent with her to the emergency room. The DON stated it was then discovered that Resident #24 had not been getting the Diltiazem. She reported that Resident #24 ' s physician was notified of the error. She also reported that one of her family members had been to the facility

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later that day and she spoke with the family about the error. The DON stated as a result of this medication error, the facility had conducted a 100% audit of all of the resident ' s MAR ' s. Both she and the Administrator reported the month end changeover process had been changed. The DON stated when she investigated the issue, she discovered that Resident #24 ' s MAR received only one check for accuracy by Nurse #2 and Nurse #4 did not compare the old MAR to the new MAR. The DON stated she talked with the staff members involved to make sure they understood the seriousness of this medication error as well as facility wide in-services for all nursing staff. She reported that Nurse #2 and Nurse #4 were still employed but the third nurse was not available. The DON stated she reported the results of the investigation to the family during a family meeting.

A telephone interview was conducted with Nurse #4 on 07/09/15 at 3:15 PM. She stated she was aware of the medication error that occurred with Resident #24. She stated Resident #24 had been transferred to a different floor. She stated all of the resident ' s charts were checked each night for any new physician ' s orders received over the last 24 hours. She stated when she checked the MARs that night it was not picked up because the Cardizem (Diltiazem) was not a new order since Resident #24 had been on it prior to being transferred. Nurse #4 stated the third shift nurses were assigned certain resident charts to check for the month end changeover to the new month ' s MAR. She stated when she did the MAR checks she compared the new MAR with the last week of physician's orders to see if there were any orders not on the new MAR. She stated Resident #24 ' s Cardizem was not transcribed

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onto the new MAR and was not picked up when she checked. She also stated that since Cardizem was not a newly ordered medication it was missed because she didn't compare the old MAR with the new one. Nurse #4 stated she didn't know what would happen if a resident was receiving Cardizem and it was abruptly stopped. She stated no one did a second check for accuracy and that was how the medication was missed. She stated she had attended an in-service on the changes to the process as well as receiving one on one education.

On 07/09/15 at 11:00 AM, the Administrator and the DON provided an action plan of correction for the medication error with Resident #24 ' s omission of Diltiazem. The DON stated the plan was written the day they discovered the error on 04/07/15. The DON also reported the plan of correction was part of their quality assurance program and included the following components:

1. An internal medication error report was done 04/07/15. The DON stated the error that had occurred was for Diltiazem HCL 180 milligrams as it was not transcribed to the new medication administration record. She stated Resident #24 was sent to the emergency room for evaluation. The physician was notified at 7:30 AM, and the family was already aware of the error. The DON stated any medication error reports were to be given to her for review and investigation.

2. An investigation was started for the incident with Resident #24 on 04/07/15 by the DON and was completed and sent to the quality assurance program on 04/15/15. The DON reported that Resident #24 ' s MAR was reviewed to determine what had happened. She stated once it was

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F 333	Continued From page 13 determined that an error had occurred, the process for month end changeover was reviewed. She reported all staff were in-serviced and the staff involved were interviewed and disciplinary action given. 3. Beginning on 04/14/15, a 100% audit was completed for all resident's MARS for the end of the month changeover from March 2015 to April 2015 and was completed on 04/15/15. No other medication errors were identified. 4. Beginning on 04/14/15, 100% of the nursing staff were educated on the updated MAR/TAR month end changeover process either in person or via telephone and all in-servicing was completed on 04/15/15. 5. The in-service education information was added to the orientation information being provided to all new nursing staff upon hire effective 04/14/15. 6. The involved staff received disciplinary action and attended the in-services. 7. A new audit tool entitled "MAR Changeover tracking audit tool " was initiated for the month end changeover beginning on 04/25/15 to 04/26/15. The DON stated supervisors were responsible for completing audits at the end of each month and forwarding those audits to her for review. She stated she would present them to the monthly quality assurance committee once she reviewed the audits. 8. A family meeting was held with Resident #24 ' s family on 04/16/15 to discuss the results of the investigation and discuss resolution of the	F 333		

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F 333	Continued From page 14 grievance for the incident. 9. The policy for Medication Orders/Medication Reconciliation was updated on 04/16/15 to include the changes for the month end changeover. It was noted on the policy that monthly printed physician order sheets and medication/treatment administration records would be sent from the pharmacy by the 25th of each month. Monthly reconciliation would be a three (3) step process. It was noted that the first licensed nurse would check the next month ' s MAR/TAR (treatment administration record) comparing to the current physician orders making any necessary corrections. The licensed nurse was to sign the bottom of the next month ' s physician order sheet indicating the reconciliation was completed and the orders were accurate. The second licensed nurse would repeat the first check and sign the bottom of the physician order sheet indicating the reconciliation was completed and the orders were accurate. The final step included a third check where the night shift licensed nurse would reconcile the new MAR/TAR with the previous month ' s MAR/TAR making any necessary corrections on the last day of the month. 10. The pharmacy consultant was to review any negative audits on a monthly basis. 11. The DON reported she would submit the results of the monthly MAR/TAR audits and the internal medication error reports to the quality assurance committee on a monthly basis until 11/01/15. She also stated all components of the plan of correction would be discussed as needed during the monthly quality assurance meetings.	F 333		

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F 333	Continued From page 15 The in-service information as well as the sign in logs for the " How to check MAR for change-over " in-service was reviewed and completed on 04/15/15. The Medication Orders/Medication Reconciliation policy had been revised as of 04/16/15 to reflect the changeover process system changes. The audits for the MAR changeover tracking tool were being done as reported. The internal medication error report for Resident #24 was reviewed. Nursing staff were interviewed and were able to communicate the changes made to the changeover process for the MARs and verified in-services were held. The audit information was taken to the quality assurance committee and remained as an active component of their quality assurance program.	F 333		
F 371 SS=D	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 and staff interview, the facility failed to maintain the temperature of tuna salad at or below 41 degrees Fahrenheit during operation of the tray line for one of two serving kitchens. The findings included:	F 371	Croasdaile Village acknowledges receipt of the Statement of Deficiencies and purposes of this Plan of Correction to the extent that the summary of findings is factually correct in order to maintain compliance with applicable rules and	7/31/15

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F 371	Continued From page 16 On 7/8/15, tray line temperatures were taken by the Nutrition Care Manager (NCM) during set-up for lunch service at 11:20 AM in the first floor warming kitchen. The first temperature for tuna salad was 48 degrees. The tuna salad was placed in the freezer to get the temperature down to 41 degrees or below before serving. On 7/8/15, tray line temps were taken by the NCM during set-up for lunch services at 11:35 AM in the second floor warming kitchen. The first temperature for tuna salad was 46 degrees. The tuna salad was placed in the freezer to get the temperature down to 41 degrees or below before serving. On 7/8/15 at 11:50 AM the NCM took a second temperature on the tuna salad that was placed in the freezer in the first floor warming kitchen and it registered at 39.3 degrees and was able to be served. On 7/8/15 at 12:00 PM the NCM took a second temperature on the tuna salad that was placed in the freezer in the second floor warming kitchen and it registered at 45.6 degrees. The NCM informed staff to place the tuna salad back in the freezer and that it was not to be served until it was below 41 degrees. On 7/8/15 at 12:15 PM the NCM took a third temperature on the tuna salad that was placed in the freezer in the second floor warming kitchen and it registered at 43.8 degrees, however, all residents requesting tuna salad on the second floor had been served despite the NCM ' s instruction to hold service of the tuna salad until it met regulatory temperatures.	F 371	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 6-9, 2015 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 the Statement of deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative of legal procedures. #1 Corrective action for the affected resident: Lunch service of food items not meeting standard was halted immediately. All Food Service team members received education on correct temperatures and holding practice for cold foods. #2: Corrective action for all resident's affected: Temperatures of cold food items were taken in all resident areas. All cold plates were placed in the freezers to facilitate lowering the temperatures to the required level. #3: Prevention Measures/Systematic Changes:	

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F 371	Continued From page 17 In an interview with the NCM on 7/9/15 at 10:45 AM, she stated that the tuna salad should have been 40 degrees when it came from the main kitchen and should have been placed in the freezers as soon as it reached the warming kitchens. The expectation was that it not be served until the temperature was in the appropriate range. She reported that she had a discussion with the staff about serving the tuna after being instructed not to, administration had also discussed it in the morning stand up meeting on 7/9/15, and in-servicing would be done to re-educate dietary staff about appropriate hot and cold food holding temperatures.	F 371	All Food Service team members were educated on appropriate temperatures and holding of all potentially hazardous foods. A discussion was held about the potential effects to residents when foods are not served at correct temperatures. Policy and Procedure for handling of cold food items was updated to include, all cold plates are to be placed in the freezer immediately upon arrival to the warming kitchens. Plates will then be served from the freezer. Bulk food items will be placed in the freezer upon arrival and iced for service. Education for proper temperatures for serving potentially hazardous foods will be reviewed daily at line meetings before food service. #4: Method of Monitoring: Dining Supervisor/Manager will review temperatures at meals for correctness. The Dining Supervisor/Manager will then sign off that the temperatures were correct. Audits will be conducted and submitted monthly to the QAPI committee during scheduled meetings. QAPI audits will be completed monthly for 6 months; additional audits will be completed based upon level of compliance.	
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	F 441		7/31/15

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F 441	Continued From page 18 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, 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 observation, record review and staff interviews, the facility failed to post an isolation sign outside a resident's door for 1 of 1 sampled residents observed for isolation precautions	F 441	Croasdaile Village acknowledges receipt of the Statement of Deficiencies and purposes of this Plan of Correction to the extent that the summary of findings is	

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F 441	Continued From page 19 (Resident #114). Findings included: A review of the Issues in Infection Control for Nursing Homes provided by the Statewide Program for Infection Control and Epidemiology (SPICE) revealed that isolation signs must be posted on the door to the resident ' s room. The SPICE program has been considered a standard by the Centers for Disease Control (CDC) as a tool for communicating the procedures that healthcare workers, family and visitors should follow to prevent cross transmission. Review of the Physician Telephone Orders dated 07/06/15 showed Resident #114 was on Contact Isolation Precautions for Methicillin Resistant Staph Aureus (MRSA) in the urine. Resident #114 was started on an antibiotic to be given twice each day for 1 week. An observation on 07/09/15 at 3:15 PM showed a chest level metal cart with drawers in an alcove between two rooms. No signage was seen on the wall above the metal cart or on the doors or doorframes of the rooms. A box of gloves was sitting on top of the cart. Closer inspection of the cart showed a Contact Isolation sign in a plastic sleeve on top of the cart underneath the box of gloves. In an interview on 07/09/15 at 3:17 PM Nursing Assistant (NA) #1 who was caring for Resident #114 stated Resident #114 was on isolation for an infection in his urine. She indicated she had been informed by the nurse that the resident was on isolation. She indicated the purpose of the sign was to let staff know the resident was on isolation. She stated the sign should be on the wall above the cart or hanging on the door. NA #1 indicated staff was aware of which residents were on isolation but visitors may not be aware anything special was needed. In an interview on 07/09/15 at 3:30 PM Nurse #1	F 441	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 6-9, 2015 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 the Statement of deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative of legal procedures. #1 Corrective action for the affected resident: The contact precautions isolation sign was immediately replaced on the resident's door. #2: Corrective action for all resident's affected: A complete audit of all residents on isolation precautions was completed and no other areas of concern were identified. #3: Prevention Measures/Systematic Changes: The nursing team was educated on the	

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F 441	Continued From page 20 confirmed that Resident #114 was on Contact Isolation Precautions. She indicated the Contact Isolation sign was on top of the cart and the sign should not have had a box of gloves covering it. She stated the public was not protected. In an interview on 07/09/15 at 3:30 PM the Director of Nursing (DON) stated it was her expectation that an isolation sign would be posted on the door or door frame of a resident's room. She indicated the purpose of the sign was to protect the staff and the public. The DON stated that in this case the public was not protected.	F 441	importance of infection control precautions and posting of isolation signs on resident's doors. Monthly audits will be conducted by DON/designee to ensure continued compliance with infection control measures. #4: Method of Monitoring: DON/Designee will complete audits of infection control procedures including posting of isolation signs on residents doorway and areas of concern will be immediately followed up on. Audits will be submitted monthly to the QAPI committee during scheduled meetings. QAPI audits will be completed monthly for 6 months; additional audits will be completed based upon level of compliance.	