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 05/25/2017

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 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to remove facial hair for 1 of 3 sampled residents that required extensive assistance with activities of daily living (Resident #104). The findings included: Resident #104 was admitted on 12/14/16. The diagnoses included, in part, Alzheimer's, dementia and osteoporosis. The annual Minimum Data Set (MDS) assessment dated 05/03/17, indicated Resident #104's cognition was severely impaired and she required extensive assistance of one person with activities of daily living (ADLs) and preferred sponge baths. The care plan dated 05/20/16 revealed Resident #104 required extensive assistance with bathing, grooming, dressing, mobility and eating. The goal included the resident needs would be met by staff, she would be kept clean, neat, dressed appropriately for the season, and free of body odor with no decline in function or range of motion through next review. The interventions were to assist with activity of daily living (ADLs) as needed to ensure safety and ensure adequate completion. During an observation on 05/23/2017 at 11:28 AM, Resident #104 was sitting in the common	F 312	Croasdaile Village acknowledges receipt of the statement of Deficiencies and purposes this Plan of Correction to the extent to 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 written allegation of compliance. Preparation and submission of this Plan of Correction is in response to CMS 2567 from May 22-25 2017 . 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. On 5/23/2017 and on 5/25/2017 resident #104 was observed to have facial hair. On 5/25/2017 during resident's bathing period, the C.N.A asked resident if she could trim her facial hairs and the resident consented. Resident #104 was	6/2/17

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

Electronically Signed | 06/09/2017

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F 312	Continued From page 1 area listening to music with other residents and had multiple long chin hairs. During an observation on 05/25/17 at 9:00 AM, Resident #104 was sitting in bed had multiple long chin hairs. During an interview on 5/25/17 at 9:18 AM, Nurse Aide (NA) # 2 indicated the nurse assigned the showers/ baths. The shower list designated shower days. NA #2 indicated during shower days the hair and nails were groomed, and resident's facial hair was trimmed or shaved daily. NA #2 indicated Resident #104 permitted her chin hairs to be trimmed. A review of the shower list revealed Resident # 104's shower days were Monday, Wednesday and Friday from 3:00 PM - 11:00 PM. During an observation and interview on 05/25/17 at 9:39 AM, NA #2 indicated to Resident #104 she needed to trim her chin hairs. Resident #104 responded with a nod and a smile. During the interview, NA #2 indicated chin hairs need to be removed when they were observed. During an interview on 05/25/17 at 10:18 AM, Nurse #4 indicated that Resident #104 had not refused ADL care. A review of the assignment sheet revealed NA #4 was assigned to Resident #104 for a shower or bath on Monday 05/22/17 during the 3-11pm shift. A review of the assignment sheet revealed there was no documentation to support the shower/bath was completed. A review of the 5/22/17 MDS ADL tracker revealed a bath was completed on the first shift.	F 312	free from facial hairs on 5/25/2017. 2. On 5/26/2017, all residents were reviewed by the Director of Nursing and Assistant Director of Nursing and C.N.A designee as it relates to completion of shaving and removal of facial hair. Appropriate shaving and removal of facial hair was completed for residents. 3. On 5/26/2017, education was started by Director of Nursing and Assistant Director of Nursing on expectation of care as it relates to grooming including shaving and removal of facial hair. Education also included review of dignity related to grooming. The Neighborhood Support Coordinator, Nursing Supervisor, Assistant Director of Nursing and / or Director of Nursing will complete grooming observations on all units. Observations will be done daily x 4 weeks, weekly x 4 weeks, then monthly x 3 months. Observations will include off shifts and weekends. The Director of Nursing will review grooming observations daily for compliance. Review will be done daily x 4 weeks, weekly x 4 weeks, then monthly x 3 months. 4. Quality Assurance and performance Improvement Committee will review the audit results and follow up on any action plans during the Quality Assurance and Performance Improvement Committee meeting. Any items on the action plan will	

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F 312	Continued From page 2 During a telephone interview on 05/25/17 at 1:24 PM, NA #4 indicated the last time she worked with Resident #104 was on 05/22/17. NA #4 indicated Resident #104 preferred a tub bath, and during the bath, hair, nails and facial hair were to be groomed. NA #4 was unable to recall what care she had provided on this date. A review of the assignment sheet revealed NA #5 was assigned to Resident #104 on Wednesday 05/24/17 to provide a shower or bath during the 3-11pm shift. There was no documentation on the assignment sheet to support the bath had or had not been provided. A review of the MDS ADL tracker on 05/24/17 revealed no bath was completed. During a telephone interview on 05/25/17 at 2:30 PM, NA #5 indicated she had not given any showers or baths during her shift to any resident on 05/24/17. NA #5 stated she had provided Resident #104 with a "good" bed bath and indicated she didn't see facial hair. NA #5 further added she documented on the assignment sheet when she completed ADL care and the nurse documented in the computer. NA #5 stated there was no place to document a bath or shower in the computer. A review of the nursing notes for the week of May 22- 25 revealed Resident #104 had not refused her bath or hygiene care. During an interview on 05/25/17 at 3:15 PM, the Director of Nursing indicated her expectation was that residents' facial hair be removed during bathing.	F 312	be completed to ensure continued compliance. Quality Assurance and performance Improvement Committee will determine if any further education is needed based on results of audits. The Quality Assurance and performance Improvement Committee has the right to discontinue the audits once the committee determines compliance has been achieved.	

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F 371	Continued From page 3	F 371		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to discard expired one Omelet station tray, one glass jar of Caper, one plastic wrap of chees, two plastic containers of mixed vegetables and Ginger in walk in cooler and one plastic bag of marshmallow in the dry storage room, failed to label one plastic bag of pasta shell and discard one dented can of Evaporated Milk, one dented can of Condensed Milk and two dented cans of Red Paper in the dry	F 371	1) On 5/22/2017, it was observed that multiple items were expired or not labeled appropriately. All expired items were discarded immediately upon observation from the survey. All items were then labeled according to the policy used for dating and labeling of food. 2) On 5/22/2017, all kitchen items were reviewed for proper dating and labeling	6/2/17

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F 371	Continued From page 4 storage room. The findings included: 1a. On 5/22/17 at 10:30 AM, during the observation of the walk-in cooler in the kitchen, there were five plates of omelet in the Omelet station tray expired on 5/20/17, one glass jar of Caper expired on 5/21/17, one plastic wrap of chees expired on 5/19/17, one plastic containers of mixed vegetables expired on 5/19/17, one plastic container of Ginger expired on 5/21/17. On 5/22/17 at 10:30 AM, during an interview, the Director of Dining indicated that all the expired food needed to be removed from the walk in cooler. 1b. On 5/22/17 at 10:35 AM, during the observation of the dry storage room, there was one plastic bag of marshmallow expired on 4/22/17. On 5/22/17 at 10:35 AM, during an interview, the Director of Dining indicated that all the expired food needed to be removed from the dry storage room. 2a. On 5/22/17 at 10:40 AM, during the observation of the dry storage room, there was one plastic bags of pasta shell without the label. On 5/22/17 at 10:40 AM, during an interview, the Director of Dining indicated that all the food needed to be labeled in the dry storage room. 2b. On 5/22/17 at 10:40 AM, during the observation of the dry storage room, there were one dented can of Evaporated Milk, one dented	F 371	procedure as well as audit of all cans to removed dented cans from the inventory. 3) On 5/31/2017, 100% education was completed with Morrison's team on the expectations for dating and labeling food as well as food storage. Dating and Labeling audits will be completed by Director of Dining or Sous-Chef daily x 4 weeks, weekly's x 4 weeks, and monthly x 3 months. The Director of Dining or Sous Chef will monitor the audits daily for compliance. Review will be done daily x 4 weeks, weekly x 4 weeks, then monthly x 3 months. 4. Quality Assurance and Performance Improvement Committee will review the audit results and follow up on any action plans during the Quality Assurance and Performance Improvement Committee meeting. Any items on the action plan will be completed to ensure continued compliance. Quality Assurance and performance Improvement Committee will determine if any further education is ended based on results of audits. The Quality Assurance and performance Improvement Committee has the right to discontinue the audits once the committee determines compliance has been achieved.	

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F 371	Continued From page 5 can of Condensed Milk and 2 dented cans of Red Paper. On 5/22/17 at 10:40 AM, during an interview, the Director of Dining indicated that all the dented cans needed to be removed from the dry storage room. On 5/22/17 at 10:45 AM, during an interview, the Sous-Chef indicated that he was responsible for keeping all the food labeled with the date of opening and appropriate expiration date. He was not aware that some food in the dry storage room and walk in cooler was not labeled or expired. On 5/22/17 at 10:50 AM, during an interview, the Director of Dining indicated that all the staff was responsible for keeping the food labeled with correct expiration date and date of opening. All the expired food and dented cans needed to be removed from the kitchen.	F 371		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 431		6/2/17

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F 431	Continued From page 6 (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the	F 431	1) During the survey that occurred	

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F 431	Continued From page 7 facility failed to store multiple medications in labeled packaging to identify the medication name, strength and expiration date in four of seven medication carts inspected. Findings included: 1. During an inspection of the single medication cart on Unit 1 South on 05/23/17 at 3:48 p.m., seven loose white tablets and one loose capsule were found in the bottom of the second drawer on the left-hand side of the cart. Medication Nurse #5 acknowledged that these medications were not labeled or stored correctly and she wasted them. 2. During an inspection of medication cart #1 on Unit 1 North on 05/24/17 at 8:56 a.m., two loose whole white tablets and one quarter white tablet were found in the bottom of the second drawer on the left-hand side. When the loose pills were shown to Nurse #6 who was giving medications, she disposed of them in the sharps container. She indicated in an interview that had she seen them underneath the bulk medications in the drawer, she would have disposed of them on discovery. 3. During an inspection of medication cart #2 on Unit 1 North on 05/24/17 at 9:04 a.m., one loose white tablet was found in the bottom of the third drawer on the left-hand side. Nurse #6 was unable to identify the medication and disposed of the tablet in the sharps container. 4. During an inspection of medication cart #1 on Unit 2 North on 05/23/17 at 9:16 a.m., two loose white tablets were found in the bottom of the second drawer on the left-hand side. Nurse #7	F 431	between May 22-25, 2017 there were multiple medication carts that had loose medications that were non narcotic. Upon observation by the surveyor, the nurse wasted the medication according to policy.On May 26, 2017 all medication carts were checked by the Assistant Director of Nursing and Director of Nursing for loose medications in medication cart drawers. All loose medications were removed at the time of cart check. 2) On May 26, 2017 all medication carts were checked by the Assistant Director of Nursing and Director of Nursing for loose medications in medication cart drawers. All loose medications were removed at the time of cart check. 3) On May 26, 2017 education began by the Assistant Director of Nursing and Director of Nursing with licensed nurses on monitoring of medication storage to include removing and replacing medication cards from medication cart in a manner to prevent inadvertent popping of medications from medication cards and removal of loose medications in medication cart drawers. The Nursing Supervisor, Assistant Director of Nursing and / or Director of Nursing will check all medication carts daily to ensure medications are stored appropriately. Medication cart checks will include monitoring for loose medications in medication cart drawers. Medication cart checks will be completed daily x 4	

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F 431	Continued From page 8 retrieved the medications and wasted them. In an interview with the Director of Nursing on 05/25/17 at 1:41 p.m., she shared her expectation that any nurse who dropped a pill into a drawer on the medication cart or who saw a loose pill in the cart would remove and waste it. She acknowledged that loose medications were not stored or labeled properly.	F 431	weeks then weekly thereafter. The Director of Nursing will review results of medication cart checks daily x 4 weeks, weekly x 4 weeks, and monthly x 3 months. 4. Quality Assurance and Performance Improvement Committee will review the audit results and follow up on any action plans during the Quality Assurance and Performance Improvement Committee meeting. Any items on the action plan will be completed to ensure continued compliance. Quality Assurance and Performance Improvement Committee will determine if any further education needed based on results of audits. The quality Assurance and Performance Improvement Committee has the right to discontinue the audits once the committee determines compliance has been achieved.	