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 06/06/2014

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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to treat a resident with dignity by refusing a resident ' s request of having a urinal by the bedside for 1 of 1 residents requesting a urinal by the bedside (resident 178). Findings included: Record review indicated resident #178 was admitted to the facility on 5/23/2014 following back surgery. The resident's cumulative admission diagnoses included Parkinson's Disease and Urinary Incontinence Review of the resident's nursing admission assessment on 5/23/2014 indicated he was alert and oriented, pleasant and had no memory impairments. The assessment also indicated he was continent of bladder and used the bedside commode with assistance from 2 people. The resident's interim care plan dated 5/23/2014 was reviewed and addressed urinary incontinence as a problem with interventions which included rule out cause of incontinence and use bedside commode. A comprehensive Minimum Data Set (MDS) was not available at the time of the survey.	F 241	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 June 2-6, 2014 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: A care concern in relations to the	6/6/14

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

Electronically Signed | 06/17/2014

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F 241	Continued From page 1 Review of the facility grievance log indicated a grievance was filed on 5/27/2014 by a family member that involved a care issue. In an interview with the administrator on 6/4/2014 at 1:00 PM, the administrator reported on 5/27/2014, she received a phone message from the resident's family member. The administrator reported she called the resident's member immediately. She stated the resident's family member reported the resident complained about disrespectful treatment he received during the night. The administrator reported she immediately sent the facility Social Worker (SW) to interview the resident. The administrator indicated the SW reported the resident alleged 2 facility staff treated him in a disrespectful manner during the night. The administrator stated she immediately called the 2 staff members in, got written and verbal statements from them and immediately suspended them until the investigation was complete. The administrator stated she informed the resident and his family member the 2 staff members were suspended from the facility pending an investigation. A 24 hour report was done per the administrator 5/27/2014. The administrator stated the team decided, based on the interview with the resident that both staff members should be terminated. The administrator also stated no other residents were interviewed during or following the facility investigation. In an observation and interview with the resident on 6/4/2014 at 3:30 PM, the resident was observed in his room. The resident was pleasant on approach and answered simple questions with appropriate answers. When asked about the	F 241	resident's dignity was submitted to the Nursing Home Administrator on the morning of 5/27/2014. Per policy, the employees involved in the allegation were removed immediately from providing are to the resident. The resident was interviewed by the Healthcare Social Worker, Licensed Nursing Home Administrator, and the Director of Nursing on different days and times to obtain and compare the timeline of the event. Per policy, family and resident were informed and involved throughout the investigation. The resident also received counseling services provided by the chaplain and talk therapy. #2: Corrective action for all resident's affected: The entire team was re-educated on dignity and respect of the resident in regards to F-241. In-service education was completed with employees on June 5, 2014 to remind them of their approach in communication, care practices, and day to day interaction with the resident must be in a way that maintains and enhances each resident's dignity and respect in full recognition of his of her individuality. Topics covered in the in-service education included but was not limited to resident appearance, resident toileting preferences, tone when speaking to residents, addressing residents by name appropriately, protecting resident confidentiality, and other related topics to Dignity and Respect for the resident.	

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F 241	Continued From page 2 incident on 5/27/2014, the resident reported 2 facility staff treated him very disrespectfully on the night shift on 5/27/2014. He reported he was told by them he could not have his urinal because he might spill the urine on his bed. He stated his hands shook at times, and the staff were concerned he would spill the urine out of his urinal. He further stated they put a brief on him, and he told them he did want a brief. When asked how the incident made him feel, the resident stated "While I was in the service in Vietnam, my plane was shot down by the Vietnamese. I landed in a rice paddy, and a North Vietnamese came up in his boat and beat me with his oar. He thought I was dead and left, but I crawled into the jungle and hid. For 3 days, I could hear them hunting for me. The only other time I felt that low was the night those 2 ladies treated me that way." The resident further stated he was pleased with the quick action of the staff when he complained about the incident, and he was satisfied with how the facility handled it. In an interview with the facility Social Worker (SW) on 6/5/2014 at 9:50 AM, the SW reported she interviewed the resident on 5/27/2014 about the complaint filed by his family member. She stated the resident was alert and oriented and deemed reliable during the interview. She stated the resident complained the 2 alleged staff members removed his urinal from his reach and placed a brief on him because his bed was wet. She stated the resident felt staff disrespected him that night. In an interview with the facility Director of Nursing (DON) on 6/5/2014 at 9:55 AM, the DON reported she interviewed the resident on 5/29/2014 as a follow up about the complaint filed by his family	F 241	#3: Prevention Measures/Systematic Changes: Resident and Family interviews will be conducted by the Social Services Department in accordance with MDS Assessment completion. Four interviews a month will be conducted and submitted for the Quality Assurance and Performance Improvement committee each month to monitor resident and family responses to track any concerns that may arise from the residents. Resident and Staff Interviews will follow the CMS Form Quality of Life Assessment Resident Interview and the CMS Survey Form Quality of Life Assessment Observation of Non-interview able Resident. #4: Method of Monitoring: Quality Assurance and Performance Improvement Committee will review the audit results and follow up on any action plan 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 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 241	Continued From page 3 member. The DON stated the resident gave the same information as he gave 2 days prior. The DON reported the resident felt he had been disrespected by the 2 staff members on that night. In an interview with the administrator on 6/5/2014 at 10:10 AM, the administrator stated the expectation was all residents should be treated with respect and dignity at all times. The 2 facility staff members who were involved in the incident were no longer employed at the facility, so interviews were not conducted. Their written statements dated 5/27/2014 were reviewed, and they both denied any wrong doing related to the incident.	F 241		