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 08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROASDAILE VILLAGE	**2600 CROASDAILE FARM PARKWAY 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
E 001	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: An unannounced Recertification survey was conducted from 8/19/19 through 8/22/19. This facility was found to be in compliance with the requirements CFR 483.73 Emergency Preparedness . Event ID 4M4V11.	E 001	This facility was found to be in compliance with the requirements CFR 483.73 Emergency Preparedness.	8/22/19
F 000	INITIAL COMMENTS There was no defecency cited as result of CI, 4M4V11, 8/22/19	F 000		
F 550	Resident Rights/Exercise of Rights	F 550		9/13/19

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

Electronically Signed | 09/15/2019

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 550 SS=D	Continued From page 1 CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her	F 550		

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F 550	Continued From page 2 rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record reviews the facility failed to provide a dignified dining experience for 2 of 5 residents (Resident # 23 and Resident # 9) reviewed for dignity. Findings included: 1. Resident #23 was readmitted to the facility on 7/16/15 with diagnoses that included Alzheimer's disease, dementia, depression disorder and anxiety disorder. A review of the most recent Minimum Data Set (MDS) assessment dated 6/10/19 marked as a quarterly assessment, revealed resident was assessed as cognitively impaired. The assessment indicated the resident required extensive to total dependence with one-person assistance for activities of daily living (ADL) including eating. Review of the recent updated care plan dated 8/11/19 revealed resident was care planned for nutrition and for ADL's due to dementia and immobility. Goal was to maintain current weight, no decline in functions related to ADL dependence. Interventions included providing ADL care and ensure adequate time for completion. Assistance with meals, offering a prescribed diet and supplement. Monitor intake, change in chewing and swallowing abilities. Resident on pureed diet. During lunch observation on 8/19/19 from 12:05	F 550	Croasdaile Village acknowledges receipt of the statement of deficiencies and purpose this Plan of Correction to the extent of 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 CMS 2567 from August 19-22, 2019. 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 of legal procedures. 1) It was observed on August 19, 2019 that a resident was not provided feeding assistance during mealtime while her tablemates were assisted with their own meals. The resident was assisted with her meal immediately. Assistant Administrator and Nurse Management worked with North Carolina SPICE (Statewide Program for Infection Control and	

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F 550	Continued From page 3 PM to 1:20 PM, Resident # 23 was observed at around 12:15 PM being wheeled into the dining room in her Geri chair and was seated at a table with other residents who needed feeding assistance. Resident # 23 was seated at the table with other residents who were served and assisted by staff with their lunch meals at around 12:25 PM. From 12:25 PM until around 12:55 PM, Resident #23 remained seated at the dining room table while her four tablemates were assisted by staff with their lunch meals. Observation revealed Resident # 23 was not served lunch until around 12:55 PM by Nurse Aid (NA)# 1. During an interview on 8/19/19 at 1:13 PM, NA # 1 stated she was told she could only feed one resident at a time and she was providing Resident #9 with assistance with her meal, so she was not able to assist Resident# 23. She indicated Resident # 23 and Resident # 9 were tablemates and were not served their lunch meal at the same time. During an interview 8/19/19 at 1:16 PM, Nurse#1 indicated staff could only feed one resident at a time and hence Resident # 23 had to wait to be assisted with feeding until NA# 1 finished assisting Resident #9 with her lunch meal. During an interview on 8/21/19 at 9: 57 AM, the administrator stated the staff should ask for help when needed. Administrator also stated it was her expectation that all residents who needed feeding assistance be fed approximately at the same time in the dining room for a dignified dining experience.	F 550	Epidemiology) and received clarification that an aide could assist two residents at a time with their meal. Aide providing assistance with meals was educated on this clarification. 2) Nurse Management team in collaboration with the dining team reviewed all residents who dine in the dining room to evaluate feeding assistance needs on September 6, 2019. Resident seating and staffing needs were evaluated and determined that there was enough staff members present to effectively assist those residents needing help following the guidance from NC SPICE on assisting two residents at a time when providing meal assistance. 3) To enhance current operations and under the direction of the Director of Nurses, all nursing staff will receive in-service training regarding state and federal requirements for proper dining room procedures that preserve the dignity of each individual in the dining room. The training will emphasize the importance of timing of meals and assisting each resident with meals simultaneously with other residents at the table. Nurse Management or appropriate designee will conduct dining room audits for all meals to ensure residents are being properly assisted with their meals that provides a dignified dining experience for individual residents and the resident population as a whole. Compliance will be monitored and achieved by conducting	

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F 550	Continued From page 4 2. Resident #9 was admitted to the facility on 8/15/17 with diagnoses that included Alzheimer's disease and dementia. A review of the most recent Minimum Data Set (MDS) assessment dated 8/12/19 marked as an annual assessment, revealed resident was assessed as cognitively impaired. Assessment indicated the resident requires extensive with one-person assistance for activities of daily living (ADL) including eating. Review of the care plan dated 8/12/19 revealed resident was care planned for nutrition and for ADL, needing extensive assistance due to dementia. Goal was to maintain current weight, no decline in functions related to ADL dependence. Interventions included the resident can occasionally self-feed and occasionally able to utilize utensils with meals but needed more cueing and assistance. When the utensil in hand, cued needed to put the food in her mouth. Aid with meals as needed. Assist with ADL's as needed to ensure adequate completion and allow adequate time for completion. Resident # 9 was observed on 08/19/19 at 12:10 PM sitting in a chair near the table with other residents who were assisted with feeding in the dining hall. Resident #9 was fed by NA # 1 at the dining table. Review of the dietary meal ticket and meal tray revealed dessert was not served to the residents at the table. Interview with dietitian on 8/19/19 at 12:23 PM revealed desserts were served later to encourage residents to consume their main meal. Continuous observation revealed on 08/19/19 at	F 550	daily audits for four weeks, weekly for four weeks, and monthly for three 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 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 550	Continued From page 5	F 550		

around 12:50 PM, Nurse Aide (NA) # 1 left the dining table to retrieve a meal tray and began feeding another resident. Resident # 9 was at the dining room table without direct supervision and was served dessert (Chocolate cream Pie) by the dietary staff. Resident # 9 was observed looking at the chocolate cream pie for few minutes and started eating the dessert with her hand. Nurse # 1 who was feeding another resident came over, cleaned Resident # 9 hand and offered her a spoon, and encouraged her to consume the dessert with the spoon. Resident # 9 attempted to feed herself the pie with the spoon but was unable. The resident was observed to spill pie on the table. Staff did not intervene further to stop the resident from spilling and dropping food as she attempted to fed herself.

During an interview on 8/19/19 at 1:13 PM, NA#1 indicated Resident # 9 had stopped consuming her meal and she moved to assist another resident with her meal. She stated she did not observe that Resident #9 was served dessert and had not offered it to her before going to provide another resident with meal assistance.

During an interview on 8/19/19 at 1:16 PM, Nurse # 1 stated she had observed Resident # 9 eating the dessert with her fingers and offered her the spoon. Nurse # 1 further stated she was unsure if NA had offered the resident her dessert.

During an interview on 8/21/19 at 9: 57 AM, administrator indicated the NA # 1 was focused on completing the feeding task for the residents. Administrator stated the staff should complete their feeding task with one resident before assist another resident for a dignified dining experience for the resident. She indicated that all residents

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F 550	Continued From page 6 who needed feeding assistance be assisted approximately.	F 550		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment.	F 640		9/2/19

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F 640	Continued From page 7 (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the discharge Minimum Data Set (MDS) assessment to reflect the discharge status for 1 of 20 residents, reviewed for resident assessment (Resident #1). Findings included: Resident #1 was admitted to the facility on 3/4/19 with diagnoses included chronic obstructive pulmonary disease, respiratory failure, and metabolic encephalopathy and pneumonia. Record review of the 30 day MDS assessment, dated 4/1/19, revealed Resident #1 had a change in therapy. Record review of physician's note, dated 4/10/19, revealed that Resident # 1's may discharge home on 4/11/19. Record review revealed Resident 1's Discharge Summary note, dated 4/11/19, read in part	F 640	1) The discharge assessment for the resident observed was completed by the MDS Coordinator on August 22, 2019 once identified as being incomplete. 2) The MDS Coordinator completed a 100% audit of all discharged residents and compared the discharged residents to the discharge register to provide assurance that all other discharged residents had received a discharge assessment as per state and federal guidelines. This was completed on 9/2/2019. 3) In order to ensure that all discharge assessments are completed timely and according to regulation requirements, the MDS Coordinator or designee will: -Ensure Resident is on the assessment schedule when discharge is scheduled. -Ensure Resident is placed on the	

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F 640	Continued From page 8 "Resident has met the goal of therapy and may transition home with home health therapy for continuity of services. Reviewed with resident and resident son discharged medication, upcoming PCP appointment and post discharge plan to prevent rehospitalization. Resident to receive services from Kindred at home. Resident provided a copy of discharged medication list, discharge medications and copy of safe transition packet." Record review of the nurses' notes, dated 4/12/19, read in part "Resident discharged on 4/11/19, spoke with discharged resident's son who states that resident is doing well, resident has taken medication, 24 hour care giver is present. He reported he has prepared medication for self-administered. Reminded how to contact healthcare navigator if needed". Record Review revealed no discharge MDS assessment. On 8/22/19 at 8:20 AM, during an interview, the MDS coordinator indicted that she was responsible for MDS assessment of Resident # 1. She stated the resident went home with his family on 4/11/19. The nurse stated she had "missed, and had not completed the discharge MDS assessment". On 8/22/19 at 8:31 AM, during an interview, the Associate Executive Director stated the resident's MDS assessments should be completed timely and accurately for all residents.	F 640	audit tool at time of discharge. -Ensure that each step of discharge completion is indicated on the audit tool. - Ensure that the comparison of the daily census and discharge schedule accurately reflects the discharges from the facility. -Administrator and/or MDS partner will check audit tool each week for four weeks and each month for three months for accuracy and completion of discharge assessments. 4) The 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 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.	