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CENTER	S FOR WEDICARE	X MEDICAID SEVAICES	1.01	(1) 7/11:	JIVIO INC	7. 0000-0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345501	B. WING	to a will a will a second	ı	0 9/ 2011
NAME OF PR	ROVIDER OR SUPPLIER	•	STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
CROASDA	AILE VILLAGE		I .	000 CROASDAILE FARM URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 157 SS=G	483.10(b)(11) NOTI (INJURY/DECLINE. A facility must imme consult with the resi known, notify the re or an interested fam accident involving the injury and has the p intervention; a signi physical, mental, or deterioration in heal status in either life to clinical complication significantly (i.e., and existing form of treat consequences, or to treatment); or a decount of the resident from the §483.12(a). The facility must also and, if known, the reconsequence or interested family change in room or respecified in §483.1 resident rights under regulations as spectation. The facility must reconstruction in the facility must reconsequences and phenomena.	FY OF CHANGES	F 157	CROASDAILE VILLAGI RESPONSE TO THIS 256 NOT DENOTE AGREEM THE STATEMENT OF DEFICIENCIES; NOR DO CONSTITUTE AN ADM THAT ANY STATED DE IS ACCURATE OR THA DEFICIENCY EXISTED. WE ARE FILING THE PO MEET THE REQUIREM ESTABLISHED BY STA FEDERAL LAW. CROAST VILLAGE RESERVES TO TO REFUTE ANY DEFICE ON THIS 2567 THROUG INFORMAL DISPUTE RESOLUTION OR FORM APPEAL PROCESS. • F157: NOTICE OF CO (INJURY/DECLINE/RC) RESIDENTS AFFECTE ALLEGED DEFICIENT PRACTICE ONE OF THE THREE RE	ES 57 DOES 1ENT WITH DES IT ISSION EFICIENCY T A DC TO ENTS TE AND SDAILE HE RIGHT CIENCIES H THE MAL CHANGES OOM, ETC.) D BY ESIDENTS	
	by: Based upon family,	IT is not met as evidenced physician and staff interviews the facility failed to notify a		REVIEWED WERE AFF THE CITED DEFICIENC FOLLOWING ITEMS W INTO PLACE FOR RESI	Y. THE ERE PUT	
		· · · · · · · · · · · · · · · · · · ·		1. X-RAY ORDERED ON		
ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TÍTLE /		(X8) DATE

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345501	B. WING			09/29) 9/2011	
	ROVIDER OR SUPPLIER	<u> </u>		26	EET ADDRESS, CITY, STATE, ZIP CODE 00 CROASDAILE FARM URHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 157	resident 's legal repr a wrist fracture requir 1 of 3 Residents (Re- condition. Findings Include: Resident #1 was adn 8/26/11 with diagnos anxiety, and peripher minimum data set da Resident #1 had a lo required limited to ex ambulation, transfer Her balance was indi exhibited wandering dated 9/7/11 indicate and exhibited episod There were intervent risk and wandering b A record review of th Resident #1 was con occurred on 9/13/11 injuries indicated. Re obtained. The contrib decline in cognition. An interview with Nur revealed she worked 9/13/11. Nurse #1 in unsteady and gets up	esentative and physician of ring physician intervention for sident #1) with a change in with a change in with a change in the sident #1 with a change in es of dementia, stroke, all neuropathy. The ted 9/6/11 indicated with mental status. She tensive assistance with and activities of daily living, cated as unsteady and she behaviors. The care plan did Resident #1 as a fall risk es of wandering behavior, ions documented for the fall ehavior. The facility fall report for ducted. It indicated a fall at 3:30pm. There were no sident #1 vital signs were putting factors to the fall were rise #1 on 9/28/11 at 3:00pm the day of the fall on dicated Resident #1 was of frequently without her	F	157	2. FALLS COMMITTEE REYFALL AND RECOMMENDES SUPERVISION IN COMMO AREAS ON 9/14/11. 3. MDS WAS REVIEWED A CARE GUIDE WAS UPDATE 9/14/11. 4. THERAPY REFERRAL A EVALUATION WAS COMPON 9/15/11. 5. WRIST SPLINT APPLIED 9/15/11. 6. PHARMACY CONSULTAREVIEWED MEDICATIONS RESIDENT #1 ON 9/16/11. RESIDENTS HAVING POTENTIAL TO BE AFFE BY THE SAME DEFICIEN PRACTICE: ALL RESIDENTS HAVE THE POTENTIAL OF BEING AFFE BY THIS DEFICIENCY. AN OF RESIDENTS WHO HAVE	ED N ND CNA ED ON ND LETED ON ANT S FOR CTED T HE FECTED AUDIT E		
	walker. Nurse #1 indicated her vitals were taken and the physician was notified the day of the fall. Nurse #1 checked Resident #1 from her toes up to her arms. She asked Resident #1 to wiggle her fingers. Resident #1 did not complain of pain. Nurse #1 did not notice any swelling or bruising.				FALLEN OVER THE PAST DAYS WAS COMPLETED T ENSURE THAT THE PHYS AND RESPONSIBLE PART WERE NOTIFIED OF ALL	30 FO ICIANS		

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CENTER	S FUR MEDICARE &	MEDICAID SERVICES				CIVID IVC	. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII			(X3) DATE SUF COMPLET	
						(5
		345501	B. WIN	IG		09/2	9/2011
NAME OF PR	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
CDOVEDA	AILE VILLAGE			2	600 CROASDAILE FARM		
CKOMSDA	THE VILLAGE			0	OURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
					CHANGES IN THE RESIDER	NTS	
F 157	Continued From page	⊋2	F	157	CONDITION. ANY COMPLI	ANCE	
	She indicated Reside	nt #1 was monitored			ISSUES FOUND IN THESE		
	throughout the shift.				AUDITS WAS ADDRESSED	BY	
					THE DON AND QA COMMI	TTEE.	
	A record review of the				(ATTACHMENT #1).	·	:
		e note dated 9/13/11 at			(**************************************		
		sident #1 was found on the of Room 129. There were no			SYSTEMIC CHANGES MA	DE TO	
		ited. At 8:10pm the Family			ENSURE THAT THE ALLE		
	Member #1 was notifi			DEFICIENT PRACTICE W			
		d of the fall and no new			NOT OCCUR:	11111	10/6/11
		The nurse note dated			MOT OCCUR.		10/6/11
		dicated the falls committee			INSERVICE WAS CONDUC	TED	
		ng the resident in supervised			ON OCTOBER 5 th and 6 th , 20		
		It indicated Family Member y that afternoon and saw			WITH ALL NURSES. TOPIC		
		ollen. Family Member #2			INCLUDED:	<i>ب</i> ى	
		e left wrist. The physician	ļ		1	,	
		ray to be conducted on the			1. PROPER NOTIFICATION OF		
	left wrist and hand. T	·			PHYSICIANS AND FAMILY M	EMBEKS.	
		e osteoarthritis of the left			2. EPISODIC DOCUMENTATION)NI	
		present. The results were			POLICY.	אוכ	
	reported to Family Me	amber#1.			TOLIC1.		
		nily Member #2 on 9/29/11 Family Member #1 was			3. EVENT REPORTING POLIC	Y.	
	notified of the fall on 9	9/13/11 and was told there			4. FALLS MANAGEMENT POI	JCY.	
		mily Member #2 visited the ound 1:30pm. She noticed			5. 72 HOUR EVENT FOLLOW-	I ID	
		ng in a wheelchair across			FORM COMPLETION.	OF	
		n. Resident #1 was leaning			TORM COMPLETION.		
	over sweeping her ha	ands across the floor. Family			6. C.N.A. CARE GUIDE		
	Member #2 bent over				COMPLETION.		
		to get her attention. Upon					
		rist, Resident #1 yelled out Member #2 then noticed			72 HOUR EVENT FOLLOW UP	•	
	the left wrist was swo			FORM IMPLEMENTED TO			
		on the elbow. The cut had			ASSESS RESIDENT SKIN, PAI	N,	
		She indicated to the Nurse			AND VITAL SIGNS FOLLOWI		

AN EVENT. (ATTACHMENT #2)

		JPPLIER/CLIA (X2) MULTIPLE CONSTRU DN NUMBER: A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345501	B. WNG	}	1	1	9/2011
NAME OF PROVIDER OR SUPPLIER CROASDAILE VILLAGE			28	EET ADDRESS, CITY, STATE, ZIP CODE 00 CROASDAILE FARM JRHAM, NC 27705		
(X4) ID SUMMARY STATEMENT OF DI PREFIX (EACH DEFICIENCY MUST BE PRE TAG REGULATORY OR LSC IDENTIFYIN	CEDED BY FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LOBE	(X5) COMPLETION DATE
to come over and view the wrist. wanted to compare both wrists. F #2 indicated the nurse decided no anything for the wrist. Family Mer requested an x-ray be conducted. report was reported as negative for Family Member #1. Family Member talked to Nurse #3 on 9/14/11 after results. Family Member #2 felt the something wrong with the wrist de results due to the increased swell and pain. Family Member #2 indireinterred the results only showed Family Member #2 then requester come by to see Resident #1 family compabout the left arm being swollen at 9/14/11. An x-ray was then reque 6:00pm. The x-ray results came to 8:00pm. Nurse #3 indicated she is results. She only saw that Reside arthritis to the left hand. She calle and notified them the results were Nurse #3 revealed she had misre She indicated when a positive or resulted, the physician should be medication, Tylenol was given to to the family had complained of point A record review of the x-ray report indicated modest osteoarthritis of but no fracture or dislocation. The indicated to have an acute fractur An interview with Nurse #4 on 9/2 revealed she was working the thir	Family Member of to implement mber #2 then. The x-ray or fractures to per #2 had then er the x-ray ere was espite the x-ray ing, bruising cated Nurse #3 d arthritis. d the physician at the wrist. 18/11 at 3:28pm plained to her and painful on ested around back around read the x-ray ent #1 had ed the family enegative. add the results. out-of-range test called. The Resident #1 due ain. 1 dated 9/14/11 the left hand e left wrist was e.	F1	157	QUALITY ASSURANCE COMMITTEE IMPLEMENTEE AUDIT TOOL TO FOLLOW U ON COMPLIANCE. (ATTACHMENT #1) MONITORING FACILITY PERFORMANCE THE QUALITY ASSURANCE COMMITTEE WILL BE CHARWITH THE RESPONSIBILITY ENSURE THAT CORRECTION ACHIEVED AND SUSTAINEE THE DIRECTOR OF NURSING AND DESIGNATED QUALITY ASSURANCE REPRESENTAT WILL CONDUCT 10 AUDITS MONTH FOR RESIDENTS WI HAVE FALLEN TO VERIFY TO COMPLETION OF PROPER NOTIFICATIONS. THE DIRECT OF NURSING WILL REPORT FINDINGS TO THE QUALITY ASSURANCE COMMITTEE OF MONTHLY BASIS FOR FURT REVIEW AND CORRECTIVE ACTION. THE QUALITY ASSURANCE COMMITTEE WI MONITOR UNTIL COMPLIAN IS ACHIEVED. THE QUALITY ASSURANCE COMMITTEE WI MONITOR UNTIL COMPLIAN IS ACHIEVED. THE QUALITY ASSURANCE COMMITTEE H THE AUTHORITY TO DISCONTINUE MONITORING ONCE THEY ARE CONFIDENTHAT THE CITED DEFICIENCY IS RESOLVED. (PLEASE SEE AUDIT TOOL-ATTACHMENT	RGED TO NIS D. G Y TIVES EACH HO THE CTOR HER ON A THER VILL NCE Y LAS G IT CY	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345501	B. WIN	G		1	C 9/2011
	OVIDER OR SUPPLIER			26	REET ADDRESS, CITY, STATE, ZIP CODE 1600 CROASDAILE FARM DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 157	received a report from results were negative description of her arm evening of 9/14/11, st prepared and came uphysician 's mailbox. report and noticed the She did not call the p fracture to the next st #4 indicated she shot regarding the x-ray research shift on 9/14/#1 was sitting out in fithroughout most of he Resident #1 had been An interview with NA revealed she was as 9/13/11, 9/14/11, and 9/15/11 at 7:00am sh discoloration to the le Nurse #2. Resident #1 throughout most of he le Nurse #2. Resident #1 throughout most of he le Nurse #2. Resident #1 throughout most of he le Nurse #2. Resident #1 throughout most of he le Nurse #2. Resident #1 throughout most of the le Nurse #2 note do indicated there was e color of the left wrist warmth to the touch. back to bed. At 12:30 by the physician after	Nurse #4 indicated she in Nurse #3 that the x-ray for fractures. There was no in reported. Later the ine was getting paper work pon the x-ray report in the Nurse #4 saw the x-ray gere was a fracture present. In hysician. She did report the inift Nurse, Nurse #2. Nurse and have called the physician sults. Issing Assistant (NA) #1 on wealed she was working the initial to the indicated Resident ront of the nursing station	F	157			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		CONSTRUCTION	(X3) DATE SUF COMPLET	
		345501	B. WIN			1	9/2011
	ROVIDER OR SUPPLIER	1		2600	T ADDRESS, CITY, STATE, ZIP CODE CROASDAILE FARM RHAM, NC 27705	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 157	orthopedic clinic for a An interview with Nur revealed a third shift x-ray was obtained o 9/15/11. There were regarding the x-ray. indicated to her the fa Resident #1 left arm Nurse #2 then went t She indicated Reside and bruised. On 9/15 physician was in use chart and was viewin piece of paper in his Physician was probat in his hand. She con going to see Residen physical changes in f indicated the physicia weekly visit. The phy	rse #2 on 9/28/11 at 3:21pm nurse reported to her that an n Resident #1 arm on no results reported to her The third shift nurse also amily had complained about being painful and swollen. o check Resident #1 arm. ant #1 left arm was swollen //11, Nurse #2 noticed the of Resident #1 medical g what appeared to be a hand. She assumed that the boly looking at the x-ray report cluded the physician was at #1 and did not report the Resident #1 arm. She an was there for his regular visician did see her and ort indicated a fracture.	F	157			
	conducted from 9/13/ was an indication of a 9/13/11. There was a result for the left wris was then an indicatio wrist during the day s A record review of the was conducted. The 9/15/11 indicated Re- ago and sustained ar There was swelling a	e facility 24-hour report was /11 through 9/15/11. There a fall without injuries on an indication of a negative t x-ray on 9/14/11. There of a fracture to the left shift on 9/15/11. e physician progress notes physician note dated sident #1 had a fall two days in injury to her left wrist. Ind tenderness with bruising. Indeed the x-ray showed a					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345501	B. WING		C 09/29/2011	
	NOVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 2600 CROASDAILE FARM DURHAM, NC 27705	03/23/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 157	fracture of the distal be sent to an orthopo physician note dated #1 has been more as An interview with the 4:37pm revealed he injuries regarding the the facility every Thu There were no reporpain or swelling of th visit, he pulled the x-and saw Resident #1 wrist. He visited Resof the left arm. He rewith bruising. When arm, she snatched b The physician sent Ficlinic after the exami An interview with Far at 5:05pm revealed fine Director of Nursiin on 9/27/11. They ad that the x-ray results An interview with the revealed she was no viewing the incident there is a fall or injurithe incident sheet an injury was noticed or x-ray should have be x-ray reports are recommonded.	radius. Resident #1 was to edic clinic for evaluation. The 9/22/11 indicated Resident gitated since her fall. physician on 9/28/11 at received an email of no ex-ray. He indicated he visits raday for his regular rounds. Its to him regarding bruising, e arm. Upon his regular ray report from his mailbox had a fracture of the left sident #1 for an examination eported the arm was swollen he touched Resident #1 left ack her arm away from him. Resident #1 to the orthopedic nation. mily Member #1 on 9/28/11 Family Member #1 met with ng (DON) and Administrator mitted to Family Member #1	F 157	• F309; PROVIDE		
F 309 SS=G	483.25 PROVIDE C/	ARE/SERVICES FOR ING	F 309	• F309: PROVIDE CARE/SERVICES FOR HIG WELL BEING	GHEST	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345501				19/29)/2011
	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 CROASDAILE FARM DURHAM, NC 27705				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.DBE	(X5) COMPLETION DATE
F 309	provide the necessar or maintain the highe mental, and psychoso accordance with the o and plan of care. This REQUIREMENT	eceive and the facility must y care and services to attain st practicable physical,	F	309	RESIDENTS AFFECTED B ALLEGED DEFICIENT PRACTICE ONE OF THE THREE RESIDENT REVIEWED WERE AFFECT THE CITED DEFICIENCY. THE CITED DEFICIENCY. THE CITED DEFICIENCY. THE CITED PLACE FOR RESIDENTO PLACE FOR PLAC	DENTS ED BY THE PUT VT #1:	
	and record reviews, the assess and report a following include: Residents Sampled (in Findings Include: Resident #1 was admits 8/26/11 with diagnose anxiety, and peripher minimum data set data Resident #1 had a low required limited to extend a modulation, transfer a Her balance was indicexhibited wandering the dated 9/7/11 indicates and exhibited episode. There were interventional risk and wandering but A record review of the Resident #1 was concocurred on 9/13/11 a injuries indicated. Resident Reside	ditted to the facility on es of dementia, stroke, al neuropathy. The led 9/6/11 indicated we cognitive status. She rensive assistance with and activities of daily living. Cated as unsteady and she behaviors. The care planed Resident #1 as a fall risk es of wandering behavior.			2. MDS WAS REVIEWED AT CARE GUIDE WAS UPDATE 9/14/11. 3. THERAPY REFERRAL AT EVALUATION WAS COMPON 9/15/11. 4. WRIST SPLINT APPLIED 9/15/11. 5. PHARMACY CONSULTAR REVIEWED MEDICATIONS RESIDENT #1 ON 9/16/11. 6. SOCIAL WORKER BEGAMONITORING RESIDENT #ANY PSYCHOSOCIAL CHAON 9/15/11 TO ENSURE RESIDENTS OVERALL WELL-BEING.	ND CNA ED ON ND LETED ON NT S FOR N	

OLNIEN	O I OIL MEDIOAILE &	WEDIOAID CERTICES				1	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345501	B. WIN	G		09/29	9/2011
NAME OF PR	ROVIDER OR SUPPLIER		•	STRE	EET ADDRESS, CITY, STATE, ZIP CODE		••
CDOVED	AILE VILLAGE			26	00 CROASDAILE FARM		
CROASDA	AILE VILLAGE			DU	URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ED BE	(X5) COMPLETION DATE
		-			RESIDENTS HAVING		
F 309	Continued From page	8 e	F	309	POTENTIAL TO BE AFF	ECTED	
	decline in cognition.				BY THE SAME DEFICIE	<u>YT</u>	
					PRACTICE:		
		se #1 on 9/28/11 at 3:00pm		1			
	revealed she worked	the day of the fall on dicated Resident #1 was			ALL RESIDENTS MAY HA	AVE THE	
		ofrequently without her			POTENTIAL OF BEING AI	FECTED	
		licated her vitals were taken			BY THIS DEFICIENCY.		
		s notified the day of the fall.					
		esident #1 from her toes up			SYSTEMIC CHANGES M	ADE TO	
		ked Resident #1 to wiggle			ENSURE THAT THE ALI	EGED	
		#1 did not complain of pain. ce any swelling or bruising.			DEFICIENT PRACTICE		
	She indicated Reside	, ·			NOT OCCUR:		10/13/11
	throughout the shift.	SHE FT WAS INCIRCION					10/13/11
	Will dag in dat title driving				INSERVICE WAS CONDU	CTED	
	A record review of the	e nurse notes was			ON SEPTEMBER 20, 2011		
		se note dated 9/13/11 at			ALL NURSES, TOPICS INC		
		sident #1 was found on the					
		of Room 129. There were no sted. At 8:10pm the Family			1. X-RAY REPORT REVIE	W AND	
		ried of the fall. At 8:20pm the			VERIFICATION WITH PH		
		d of the fall and no new				10101111	
	i ' *	. The nurse note dated		ļ	2. SKIN ASSESSMENT		
		dicated the falls committee			COMPLETION		
		ng the resident in supervised			Com Elition		
		It indicated Family Member y that afternoon and saw			3. 72 HOUR EVENT FOLL	OW.IP	
		ollen. Family Member #2			DOCUMENTATION	J 11 O1	
		e left wrist. The physician	1		DOCOMENTATION		
		ray to be conducted on the]				
		The x-ray results were			4. DOCUMENTING SKIN I	Paliba	
		e osteoarthritis of the left			IN CARETRACKER	OTOPO	
		s present. The results were		Ì	IN CARLITACKER		
	reported to Family M	ember#1.			5 ACCECCIMO EOD DAIN		
					5. ASSESSING FOR PAIN,	NG ON	***************************************
	An interview with Far	mily Member #2 on 9/29/11	Ī		SWELLING, AND BRUISII EACH SHIFT FOLLOWING		
		Family Member #1 was				JAN	
	i		1		EVENT.		l .

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMBINO	. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SUF COMPLETO	Đ
		345501	B. WIN	IG		09/2	9/2011
				I		1 00,2,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
NAME OF PR	OVIDER OR SUPPLIER			1	EET ADDRESS, CITY, STATE, ZIP CODE 800 CROASDAILE FARM		
CROASDA	AILE VILLAGE			ı	URHAM, NC 27705		
	CULA MADV OT	ATEMENT OF DEFICIENCIES	ID	L	PROVIDER'S PLAN OF CORRECT	ION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFIDIENCES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
					INSERVICE WAS CONDUC	CTED	
F 309	Continued From page	e 9	F	309	ON <u>OCTOBER 5, 2011</u> WIT	'H ALL	
		9/13/11 and was told there			NURSES. TOPICS INCLUD		
		mily Member #2 visited the			TOROLO: . O. TOD IT OLO		
		ound 1:30pm. She noticed			1. PROPER NOTIFICATION	JOE	
		ng in a wheelchair across					
		n. Resident #1 was leaning			PHYSICIANS AND FAMIL	Υ	
	over sweeping her ha	ands across the floor. Family			MEMBERS.		
	Member #2 bent ove						
		to get her attention. Upon			2. EPISODIC DOCUMENTA	ATION	
		vrist, Resident #1 yelled out			POLICY.		
		Member #2 then noticed					
		ollen and misshapen. There			3. EVENT REPORTING PO	LICY.	
		on the elbow. The cut had					
		She indicated to the Nurse w the wrist. The Nurse			4. FALLS MANAGEMENT		
		oth wrists. Family Member			POLICY.		
		e decided not to implement			TOLICT.		
		. Family Member #2 then			5 72 HOLD EVENT FOLL	OIL MC	
		e conducted. The x-ray			5. 72 HOUR EVENT FOLLO	JW-UP	
		as negative for fractures to			DOCUMENTATION		
	Family Member #1.	Family Member #2 had then					
		n 9/14/11 after the x-ray			6. C.N.A. CARE GUIDE		
	results. Family Mem				DOCUMENTATION		
		h the wrist despite the x-ray					
		reased swelling, bruising			TEAM MEETING HELD O	N	
		mber #2 indicated Nurse #3 only showed arthritis.			OCTOBER 11, 2011 WITH	ALL	
	ł .	nen requested the physician			NURSING TEAM MEMBEI		
		dent #1 about the wrist.			TOPICS INCLUDED:		
	00,110 0) 10 000 1100.				TOTIOS ITOEOEEE.		
	An interview with Nu	rse #3 on 9/28/11 at 3:28pm					
		1 family complained to her			1 COMBLABIT STIDVEY		
		ing swollen and painful on			1. COMPLAINT SURVEY		
		as then requested around			FINDINGS		
		esults came back around					
		dicated she read the x-ray			2. POST FALL ASSESSME	NTS	
		w that Resident #1 had					
	arthritis to the left had	nd. She called the family eresults were negative.			3, 72 HOUR REPORT		
	and notined them the	гозина мете педануе.			DOCUMENTATION		+

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				T	. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SUR COMPLETE	
			A. BUI	LDING			;
		345501	B. WiN	IG		1	/2011
NAME OF PR	OVIDER OR SUPPLIER			1	EET ADDRESS, CITY, STATE, ZIP CODE		
CBOVEDA	ILE VILLAGE				00 CROASDAILE FARM		
OROASUA	MEE VILLAGE			DI	URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
-					4. PHYSICIAN/FAMILY		
F 309	Continued From page	e 10	F	309	NOTIFICATION		
		ne had misread the results.					
		a positive or out-of-range test		İ	5. OVERALL DOCUMEN'	FATION	
	resulted, the physicia	an should be called. The			. O This ind Dood Here		
	medication, Tylenol v	vas given due to the family			72 HOUR EVENT FOLLO	_{W 11D}	
	had complained of pa					1	!
				j	FORM IMPLEMENTED T	1	•
	A record review of th	e x-ray report dated 9/14/11			RESIDENT SKIN, PAIN, A		
		eoarthritis of the left hand			VITAL SIGNS FOLLOWN		
		location. The left wrist was			EVENT. (ATTACHMENT	#2)	
	indicated to have an	acute tracture.					
	An internation with the	rse #4 on 9/29/11 at 3:37pm			QUALITY ASSURANCE		
		rse #4 on 9/29/11 at 3:37pm orking the third shift on		ļ	COMMITTEE IMPLEMEN	NTED	
	9/13/11 and 0/14/11	Nurse #4 indicated she			AUDIT TOOL TO FOLLO		
		m Nurse #3 that the x-ray			ON COMPLIANCE.		
	results were negative	e for fractures. There was no			(ATTACHMENT #1)		
		n reported. Later the	1		(TITITE TATE (TITITE)		
		she was getting paper work					
	prepared and came	upon the x-ray report in the			MONIMODING EL CITA	ν τ /	
	physician 's mailbox	. Nurse #4 saw the x-ray			MONITORING FACILIT	<u>. Y</u>	
	report and noticed th	ere was a fracture present.	1		PERFORMANCE		
		physician. She did report the			THE QUALITY ASSURAN		
		hift Nurse, Nurse #2. Nurse			COMMITTEE WILL BE C		
		ould have called the physician			WITH THE RESPONSIBII		
	regarding the x-ray r	esuits.			ENSURE THAT CORREC		
	An intoniou with No.	rsing Assistant (NA) #1 on			ACHIEVED AND SUSTA		
	9/28/11 of 5/36pm rd	evealed she was working the					
		/11. She indicated Resident					
		front of the nursing station			THE DIRECTOR OF NUR	SING	
	throughout most of h	ner shift. She noticed					
	Resident #1 had bee	en more agitated after her fall.			AND DESIGNATED QUA		
					ASSURANCE REPRESEN		
		4#2 on 9/29/11 at 10:12am			WILL CONDUCT 10 AUD		
		ssigned to Resident #1 for			EACH MONTH FOR RES		
		d 9/15/11 on day shifts. On			WHO HAVE FALLEN TO		
	9/15/11 at 7:00am s	he noticed swelling and			THE COMPLETION OF P	ROPER	

discoloration to the left arm. She reported this to

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		ND HUMAN SERVICES				FORM	APPROVED
····	· · · · · · · · · · · · · · · · · · ·	MEDICAID SERVICES				T") <u>. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	EO
		345501	B. Wil	IG		1	0 9/ 2011
NAME OF PR	OVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
000100				1	2600 CROASDAILE FARM		
CROASDA	VILE VILLAGE			1	DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
					OF NURSING WILL REPO	RT HER	
F 309	Continued From page	e 11	F	309	FINDINGS TO THE QUALI	TY	
	· -	#1 was eating lunch around			ASSURANCE COMMITTED		
		NA #4 saw a hot dog was			MONTHLY BASIS FOR FU		
		l left hand. Resident #1			REVIEW AND CORRECTIV		
		onto the plate as if she might			3	A E	
		d could not hold the hot dog.			ACTION. THE QUALITY	- ***** *	
					ASSURANCE COMMITTED		
		ated 9/15/11 at 10:30am			MONITOR UNTIL COMPL		
		dema to the left wrist. The			IS ACHIEVED. THE QUAL	ITY	
		was purple and blue with			ASSURANCE COMMITTE	E HAS	
		The resident was brought			THE AUTHORITY TO		
		Opm Resident #1 was seen			DISCONTINUE MONITOR	ING	
		reviewing the x-ray report.			ONCE THEY ARE CONFID		
		Resident #1 to go to an			THAT THE CITED DEFICI		
	orthopedic clinic for a	fracture to the left wrist.				BINCI	
	An intonvious with Nur	se #2 on 9/28/11 at 3:21pm			IS RESOLVED.		
		nurse reported to her that an			(ATTACHMENT #1).		
		n Resident #1 arm on					
		no results reported to her					
		The third shift nurse also					
		amily had complained about					
		being painful and swollen.					
		o check Resident #1 arm.					
	She indicated Reside	nt #1 left arm was swollen					
	and bruised. On 9/15	/11, Nurse #2 noticed the					
	{ • •	of Resident #1 medical					
		g what appeared to be a					
		hand. She assumed that the					
		bly looking at the x-ray report					
		cluded the physician was					
		t #1 and did not report the					
		Resident #1 arm. She					
		an was there for his regular					
		rsician did see her and ort indicated a fracture.					

An interview with Nurse #2 on 9/28/11 at 4:30pm indicated she did not recheck Resident #1 left

AND PLAN OF CORRECTION IDENTIFICATION NUMBER	ER: A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
345501	B. WIN	G			9/2011		
NAME OF PROVIDER OR SUPPLIER CROASDAILE VILLAGE	•	STREET ADDRESS, CITY, STATE, ZIP CODE 2600 CROASDAILE FARM DURHAM, NC 27705					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FU TAG REGULATORY OR LSC IDENTIFYING INFORMATI			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE COMPLETION THE APPROPRIATE DATE			
F 309 Continued From page 12 arm after her initial observation on 9/15/11. An interview with Nurse #2 on 9/29/11 at 9:3 revealed when she examined Resident #1 w around 8:00am on 9/15/11. The third shift nt reported to her about the family complaints opain, swelling and bruising of the left arm. Hexamination of the arm involved looking at the arm. She touched the front of the forearm at hand. This was documented on a 24-hour rescheindicated nurses communicate with each shift. Their reports are documented on the 2 hour report. The day shift nurse gets a new at the beginning of the shift. When third shift approaches, the sheet is completely filled outiled. A record review of the facility 24-hour report conducted from 9/13/11 through 9/15/11. The was an indication of a fall without injuries on 9/13/11. There was an indication of a negative result for the left wrist x-ray on 9/14/11. The was then an indication of a fracture to the left wrist during the day shift on 9/15/11. A record review of the physician progress now was conducted. The physician progress now as conducted. The physician note dated 9/15/11 indicated Resident #1 had a fall two ago and sustained an injury to her left wrist. There was swelling and tenderness with bruithe physician indicated the x-ray showed a fracture of the distal radius. Resident #1 was be sent to an orthopedic clinic for evaluation, physician note dated 9/22/11 indicated Resident #1 has been more agitated since her fall. An interview with the physician on 9/28/11 at 4:37pm revealed he received an email of no	2am rist urse of er eleft and eport. h '4 sheet t and was ere tee to tes days sing. s to The Jent	309					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345501	B. Win			09/	C 29/2011
NAME OF PROVIDER OR SUPPLIER CROASDAILE VILLAGE				2	REET ADDRESS, CITY, STATE, ZIP CODE 2600 CROASDAILE FARM DURHAM, NC 27705		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN O PREFIX (EACH CORRECTIVE AC TAG CROSS-REFERENCED TO DEFICIEN		TION SHOULD BE COMPLÉTION THE APPROPRIATE DATE	
F 309	the facility every Thur There were no reports pain or swelling of the visit, he pulled the x-rand saw Resident #1 wrist. He visited Resi of the left arm. He rep with bruising. When harm, she snatched ba The physician sent Reclinic after the examin A record review of me physician order was s 650 milligrams (mg) e The order was change times daily. The indic was for pain. An interview with Fam at 5:05pm revealed Fathe Director of Nursing on 9/27/11. They adm that the x-ray results we have led she was notiviewing the incident rethere is a fall or injury; the incident sheet and injury was noticed or s x-ray should have beex-ray reports are recei	x-ray. He indicated he visits seay for his regular rounds. It is to him regarding bruising, warm. Upon his regular any report from his mailbox had a fracture of the left dent #1 for an examination ported the arm was swollen the touched Resident #1 left ck her arm away from him. The exident #1 to the orthopedic ation. Indications revealed a started on 9/15/11 for Tylenol exercised years four hours as needed. The end of the medication was for the medication. Indications revealed a started on 9/15/11 for Tylenol exercised years for the medication was for the medication.	F	309			