**NAME OF PROVIDER OR SUPPLIER**
CROASDAILE VILLAGE

**STREET ADDRESS, CITY, STATE, ZIP CODE**
2600 CROASDAILE FARM
DURHAM, NC 27705

**DATE SURVEY COMPLETED**
07/26/2013

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
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<td>F 000</td>
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<tr>
<td>F 356 SS=C</td>
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</tbody>
</table>

**SUMMARY STATEMENT OF DEFICIENCIES**

<table>
<thead>
<tr>
<th>EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>No deficiencies were cited as a result of the complaint investigation survey of 7/26/13. Event ID# NYQX11.</td>
</tr>
</tbody>
</table>

**POSTED NURSE STAFFING INFORMATION**

- The facility must post the following information on a daily basis:
  - Facility name.
  - The current date.
  - The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
    - Registered nurses.
    - Licensed practical nurses or licensed vocational nurses (as defined under State law).
    - Certified nurse aides.
    - Resident census.

**PROVIDER'S PLAN OF CORRECTION**

- Croasdaile Village acknowledges receipt of the Statement of Deficiencies and purposes 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 26, 2013 survey.

**Laboratory Director's or Provider's Signature**

<table>
<thead>
<tr>
<th>TITLE</th>
<th>DATE</th>
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</thead>
<tbody>
<tr>
<td>LNHA</td>
<td>8-14-2013</td>
</tr>
</tbody>
</table>

**Event ID:** NYQX11

*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.*
CROASDAILE VILLAGE

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<tr>
<td>F 356</td>
<td>Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to post daily nurse staffing in the facility. Findings included: On 7/22/2013 at 4:35 PM, the daily nurse staffing form was observed hung on the bulletin board beside the 2 south nursing station. The staffing posted was for the date 7/19/2013. On 7/22/2013 at 4:39 PM, the daily nurse staffing form was observed hung on a bulletin board inside the enclosed 2 north nursing station. The staffing posted was for the date 7/19/2013. In an interview with the facility administrator on 7/22/2013 at 5:00 PM, the administrator reported the expectation was nurse staffing should be posted every day.</td>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>Date of Completion</th>
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<td>F 356</td>
<td>#2 Administrator educated Scheduler on 7/22/13 on the regulations related to the posting of daily staffing. Staffing form was updated. After the exit conference on 7/26/13, Administrator held another meeting with Scheduler reviewing the survey week and reiterating the importance of updating the daily staffing form. On 8/16/13, Administrator and DON presented expectations for staffing posting to the Scheduler for accountability. (See Attachment #1)</td>
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<td>#3 The Quality Assurance Chairperson or designee will conduct weekly audits (See attachment #2) at all nursing units to ensure that the staffing sheet is posted, updated, and contains information including but not limited to (See Attachment #3):</td>
<td></td>
</tr>
</tbody>
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- Facility name
- Current date
- Total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
  - Registered nurses
  - Licensed practical nurses of licensed vocational nurses (as defined under State law).
  - Certified nurse aides
- Resident census.
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| F 356        | Continued From page 1
This REQUIREMENT is not met as evidenced by:
Based on observations and staff interview, the facility failed to post daily nurse staffing in the facility.

Findings included:

On 7/22/2013 at 4:35 PM, the daily nurse staffing form was observed hung on the bulletin board beside the 2 south nursing station. The staffing posted was for the date 7/19/2013. On 7/22/2013 at 4:39 PM, the daily nurse staffing form was observed hung on a bulletin board inside the enclosed 2 north nursing station. The staffing posted was for the date 7/19/2013.

In an interview with the facility administrator on 7/22/2013 at 5:00 PM, the administrator reported the expectation was nurse staffing should be posted every day. |
| F 356        | Weekday and Weekend staffing schedules will be monitored by Administrator and Director of Nursing, or designee and follow up actions implemented to ensure that staffing information sheet is current and accurate. #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.
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Croasdaile Village  
**Street Address, City, State, Zip Code:** 2600 Croasdaile Farm, Durham, NC 27705  
**Provider Identification Number:** 345501  
**Date Survey Completed:** 08/14/2013

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 000</td>
<td><strong>Initial Comments:</strong> This Life Safety Code (LSC) survey was conducted as per the Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type II construction, two story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows: <strong>NFPA 101 Life Safety Code Standard</strong> Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</td>
<td>K 000</td>
<td><strong>Corrective Action:</strong> Maintenance Department contracted with Croasdaile's licensed electrician to install single outlets behind locked doors E-109, E-171, E-209, and E-272. All mechanical lift chargers will now be housed inside these rooms. Rooms are locked and will be under the Supervision of the nursing team.</td>
<td>09/04/2013</td>
</tr>
</tbody>
</table>
This STANDARD is not met as evidenced by: 42 CFR 483.70(a)  
By observation on 8/14/13 at approximately noon the following obstruction to means of egress was observed as non-compliant, specific findings include; batteries to equipment were being recharged in the corridor at 1 south east, near E176 Exit without visible supervision or enclosed within a storage room. | K 072         | **Identifying Life Safety Issue:** The Plant Operation Director and Healthcare Administrator will complete audit to ensure that corrective action is in place and functioning properly. | 09/05/2013     |
| SS=0          | **Systematic Changes:** Maintenance Technician will utilize Preventative Maintenance Software to generate monthly Audit Checks to ensure |               |                                                                                                             |                 |

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**Laboratory Director's or Provider/Supplier Representative's Signature:**  
**Title:**  
**Date:** 08/18/2013  
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 patient. (See Instructions.) Except for nursing homes, the findings stated above aredisclosable 30 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.
**K 000 INITIAL COMMENTS**

This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type II construction, two story, with a complete automatic sprinkler system.

The deficiencies determined during the survey are as follows:

- **K 072 NFPA 101 LIFE SAFETY CODE STANDARD**
  - SS=D Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10

  This STANDARD is not met as evidenced by:
  - 42 CFR 483.70(a)
  - By observation on 8/14/13 at approximately noon the following obstruction to means of egress was observed as non-compliant, specific findings include; batteries to equipment were being recharged in the corridor at 1 south east, near E176 Exit without visible supervision or enclosed within a storage room.

**K 000 Corrective Action is in compliance. (Attachment #1 & #2). Completed work orders will be submitted to Healthcare Administrator monthly for review.**

**K 072 Monitored:**

- Plant Operations Director and Healthcare Administrator will Audit Compliance weekly during rounds. Monthly PM orders will be submitted To the Quality Assurance and Performance Improvement Committee For review. QAPI committee will has the right to discontinue the audits once the committee determines compliance has been achieved.