

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/25/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345501	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2026
NAME OF PROVIDER OR SUPPLIER Croasdaile Village		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 Croasdaile Farm Parkway Durham, NC 27705	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews with staff, the facility failed to provide a safe transfer for Resident #2 when Nurse Aide (NA) #1 transferred Resident #2 from her wheelchair to the bed without using a mechanical lift causing Resident #2 to sustain a laceration to her lower left leg. The resident was prescribed a blood thinner twice a day which increases the risk of bruising and bleeding. Resident #2 was transferred to the hospital for evaluation and treatment where it was noted the laceration was 25 centimeters (9.8 inches) in length and had a depth of 20 millimeters (0.7 inches) with extensive bleeding. The laceration was closed with 11 sutures and a dressing was applied. The deficient practice occurred for 1 of 2 residents reviewed for supervision to prevent accidents (Resident #2). Findings included: Resident #2 was admitted to the facility on [DATE] with diagnoses including Alzheimer's dementia and atrial fibrillation. The physician order dated 2/23/2025 revealed Resident #2 was prescribed Eliquis 2.5 milligrams (mg) twice daily for atrial fibrillation. Review of the Medication Administration Record (MAR) for December 2025 and January 2026 revealed Resident #2 received Eliquis 2.5mg twice daily through the morning dose on 1/8/2026. Further review of the January 2026 MAR revealed Eliquis was held from the evening dose on 1/8/2026 through 1/11/2026. A physician order dated 10/11/2025 specified Resident #2 required mechanical lift for transfers. Review of the active care plan implemented on 3/18/2025 revealed that Resident #2 required a mechanical lift for transfers. The interventions included for Resident #2 to be transferred by mechanical lift using a small size sling. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was severely cognitively impaired and dependent on all movements including being dependent on staff for transfers. The MDS revealed Resident #2 did not have any functional limitation in range of motion. The facility's initial allegation report dated 1/8/2026 revealed Resident #2 received a skin laceration to her left leg while being transferred from the wheelchair to the bed by NA #1. A physician order dated 1/12/2026 revealed Resident #2's Eliquis 2.5mg twice daily for atrial fibrillation was resumed. The facility's investigation report dated 1/14/2026 revealed while NA #1 was transferring Resident #2 from the wheelchair to the bed Resident #2's left leg went behind a protruding part of the wheelchair where the footrest was attached. The facility investigation report stated it was a blunt protrusion on the wheelchair which caused a laceration. Resident #2 was transferred to the hospital and received sutures. Resident #2's wheelchair was padded on the protruding part. The facility later replaced Resident's wheelchair with a medical recliner. The facility unsubstantiated the neglect allegation. NA #1 was contacted via phone. A voicemail was left on 4/7/2026 at 1:26PM and 4/8/2026 at 8:57AM as well as a text message on 4/7/2026 1:45PM. NA #1 was not interviewed during the investigation due to no response. Review of NA #1's undated witness statement revealed she confirmed she was assigned to Resident #2 on 1/7/2026 and had previously cared for the resident and was familiar with her needs. NA #1 reported as she was preparing to transfer Resident #2 into bed there was no sling under her, so she assumed Resident #2 was a stand pivot transfer. NA #1 indicated she was able to transfer Resident #2 to bed without difficulty and the resident participated. There were no signs or symptoms of pain during or after the transfer. NA #1 (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	stated while she was placing Resident #2's legs in the bed she saw blood dripping from her, and she immediately stopped and got the nurse because she did not know where the blood was coming from. It was further documented NA #1 stated she was aware of the care guide and received orientation when she started working at the facility through the agency. Nurse #1 was interviewed via telephone on 4/7/2026 3:04PM. She stated that she was familiar with Resident #2 and knew Resident #2 was a mechanical lift transfer as Resident #2 had been the entire time of Nurse #1's employment, which had been about 2 years. Nurse #1 confirmed she was working 1/7/2026 at the time of the incident and was assigned to Resident #2. Nurse #1 stated NA #1 transferred Resident #2 without the mechanical lift when the laceration occurred. Nurse #1 stated that NA #1 ran from the room and retrieved her for help. Nurse #1 said when she entered the room, she saw a lot of blood coming from Resident #2's left lower leg and noticed the skin was split. She said she had to apply a lot of pressure on the wound to get the bleeding under control. Nurse #1 stated she could tell Resident #2 was in pain because Resident #2 was grimacing. Nurse #1 discussed not being familiar with NA #1, as NA #1 was an agency employee. Nurse #1 thought the laceration was an accident and NA #1 did not mean to hurt Resident #2. Review of the hospital Discharge summary dated [DATE] at 9:22AM for encounter dated 1/7/2026 revealed Resident #2 presented with a quite extensive left lower leg laceration. Document revealed uncontrolled bleeding upon arrival to emergency department. Laceration wrapped from posterior ankle up to below the left knee. The laceration had a length of 25 centimeters and depth of 20 millimeters. Wound was closed with 11 sutures and dressing was applied. Interview with Nurse #3, the wound care nurse, on 4/7/2026 at 1:52PM revealed she performed wound care with the wound physician for Resident #2 beginning on 1/9/2026. Record review showed Resident #2's wound was resolved on 1/29/2026 per the wound care physician's documentation. Interview with the Administrator on 4/8/2026 at 11:15AM revealed the facility believed the incident with Resident #2 was an accident and was unsure why NA #1 did not use the mechanical lift. She discussed education was completed with NA #1 related to following resident care plans and transfers. The facility provided a corrective action plan for past noncompliance which was reviewed and not acceptable.		