DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/31/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING B. WING	05/25/2011

RECEIVED JUL 05 2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	321 EAST CARVER STREET DURHAM, NC 27704

(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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to insure residents' private information was not overheard by others. On 5/23/2011 at 2:00 PM, the nurse practitioner	F 164	The facility does ensure that each resident has the right to their personal privacy. **RESIDENT IDENTIFIED AND IDENTIFYING OTHER RESIDENT'S AT RISK** No residents were identified from this citation. Once notified of this citation the facility immediately notified the Facility doctor and the Nurse Practitioner of this deficient practice. **PROCESSES IMPLEMENTED TO PREVENT FURTHER OCCURRENCES** 1. All Staff were in-serviced on 6/14/11 By the DON/designee on the following: a. Maintaining residents privacy b. HIPPA Regulations. c. Facility policy on Resident Rights. All department heads will conduct 3 rounds per week on their assigned hallways to ensure that Dignity/Privacy is maintained. (see QA tool) 2. Privacy and Dignity will be added as a topic for discussion at the monthly resident's council meeting.	6/14/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: W. K. [signature]
TITLE: Administrator
(X6) DATE: 6/30/11

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 164	Continued From page 1 (NP) and the facility doctor were observed at the 300 hall nursing station. The NP gave verbal report to the facility doctor for several residents. The NP stood at the counter inside the nurse's station, and the doctor stood at the counter on the hallway side, alongside this writer. Information reported by the NP to the doctor included medications residents were taking along with residents' medical conditions. Information was also shared verbally regarding a family's concern about a resident that was voiced to the nurse practitioner. Six residents were seated in their wheelchairs around the nursing station and in near proximity to the doctor and NP. Numerous staff people and other unidentified people walked by the NP and the doctor while verbal reports were given. Information reported to the doctor was easily overheard by this writer. The verbal reports continued over a period of serveral minutes. The facility Administrator reported in an interview on 5/25/2011at 2:20 PM it was his expectation verbal reports regarding residents should be done in a private area.	F 164	**MONITORING** 1. All QA tools will be reviewed at the daily QA committee meeting. Any discrepancies/trends will be noted and plans will be modified as needed by the team. 2. This QA process will continue until substantial compliance is obtained. At that time the QA committee will review its findings and if no trends are identified, this QA process will then modified as determined by the QA committee. 3. The Administrator, Director of Nursing or designee will conduct at least quarterly in-servicing on residents dignity and HIPPA regulations. 3. The Administrator is responsible for compliance. The facility will be in substantial compliance on 6/14/11	
F 464 SS=D	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced	F 464		

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F 464	Continued From page 2 by: Based on observation and staff interviews, the facility failed to provide an appropriate height table in the dining room for 1 of 1 resident (# 104). The findings include: Resident #104 was admitted to the facility on 12/01/03 with cumulative diagnoses that included Dementia, TIA's (mini strokes), Back Pain and Compression Fractures. The resident was coded on the most recent MDS (minimum data set) dated 04/29/11 as having short and long term memory problems and as being severely impaired in the decision making process. In addition, the resident was coded as requiring extensive assistance with all ADL's (activities of daily living) and as being independent in eating after set up. A review of the resident's CAA's (care area assessments) dated 11/13/10 revealed that the resident had a pattern of leaving 25% of her food uneaten, had advanced dementia, and needed constant cueing. A review of the resident's care plan dated 04/23/11 had listed as a problem " Potential for aspiration related to swallowing." The goal was (name of resident) will show no signs or symptoms of aspiration through the next review." The interventions included "nurses seat resident upright for all meals." The resident was observed on 05/23/11 at the lunch meal sitting at a table in the dining room in the secure unit. The resident was sitting in a wheel chair and her chin was about 4 inches from the top of the table. From time to time the resident would try to sit up better but was not able to maintain the position. As she ate, she would take the small dishes off the tray and hold them in	F 464	The facility does ensure that each dining room is adequately furnished for each resident needs. **RESIDENT IDENTIFIED AND IDENTIFYING OTHER RESIDENT'S AT RISK** R 104 was assessed and an appropriate height dining room table was provided No residents were identified from this citation. Once notified of this citation the facility immediately reviewed all other residents to ensure that their dining needs were met. **PROCESSES IMPLEMENTED TO PREVENT FURTHER OCCURRENCES** 1. All Department heads were in-serviced on 6/14/11 by the DON on the following: a. Providing resident accommodations. b. Properly assessing residents to ensure their needs are met c. Facility policy on Resident Rights. 2. All department heads will conduct at least 3 rounds per week on their assigned Dining rooms to ensure that all residents dining needs are met. (see QA tool) 3. All other residents were assessed to ensure their dining needs were met.	6/14/11

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F 464	Continued From page 3 her hands and eat from them. During an interview with nurse aide #1 at 11:55AM on 05/23/11 it was revealed "the food is at eye level, I think that's where it's supposed to be. She seems to eat ok." During an interview with nurse aide #2 on 05/23/11 at 12:15 PM it was revealed "the table might be a little to high for her but she eats ok. We hand her the sandwich and she can hold the small dishes. Other residents seem to be sitting higher up." During an observation of the resident on 05/24/11 at 11:55 AM the resident was sitting at a different table in the dining room on the secured unit. The resident still was to low to the table and was observed again to be taking the small dishes and other items off the tray and holding them in her hands while she ate. The resident only smiled at me when I tried to ask her if she was comfortable. During an interview with the Director of Nursing on 05/25/11 at 1:14 Pm it was revealed "I would expect that the staff would be sure that the resident was sitting at a level that would be good for eating."	F 464	**MONITORING** 1. All QA tools will be reviewed at the daily QA committee meeting. Any Discrepancies/trends will be noted and plans will be modified as needed by the team. 2. This QA process will continue until substantial compliance is obtained. At that time the QA committee will review its findings and if no trends are identified, this QA process will then modified as determined by the QA committee. 3. All residents will be assessed upon admission and at least quarterly there after to ensure Their dining needs are met. 4. The DON/designee is responsible for compliance. The facility will be in substantial compliance on 6/14/11	