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 _____	05/18/2012

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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	Carver Living Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the Summary of Findings is factually correct in order to maintain compliance with applicable rules and the provision of quality care to our residents. The plan of correction is submitted as a written allegation of compliance. Carver Living Center'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 stated deficiencies in this report are accurate. Carver Living Center reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceeding or any administrative or legal proceedings.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	administrator	6/7/12

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 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and family interview, the facility failed to complete or submit a twenty four hour report to the state agency for 1 of 1 sampled resident (Resident #4), who reported an allegation of being physically hit by a facility staff. Findings included: Resident #4 was readmitted into the facility on 7/15/11. Diagnoses included Biploar, Dementia, Psychosis, Cerebrovascular Accident, Hemiplegia, and Hemiparesis. The most recent quarterly Minimum Data Set (MDS) completed on 4/12/12 indicated Resident #4 was cognitively intact. Disorganized thinking was indicated as present/fluctuated in that the behavior comes and goes and changes in severity. There was no indication of an acute onset mental status change. Behaviors included delusions and verbal behavior symptoms directed toward others. Rejection of care was indicated as occurred within 1 to 3 days of the MDS assessment. The MDS documented Resident #4, required extensive assistance with bed mobility and toileting. Transfers, dressing, eating and hygiene were indicated as occurred once or twice with one to two person assist. A review of the facility's receipt of concern (grievance) completed on 5/12/12 (corrected date is 5/13/12 per Nurse #1 interview on 5/15/12 at 1:07 pm) revealed a written concern initiated by Resident #4's relative. Documentation indicated the relative notified Nurse #1 of two bruises to	F 225	F 225 1. Once notified of the allegation in regards to resident #4 the facility completed the 24 hour report and 5 day investigation will follow at completion of investigation. The staff member that failed to notify facility of bruising to be given disciplinary action and re-education on 5/15/2012.	June 12, 2012

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F 225	Continued From page 2 Resident #4's face (right temple, left jaw - yellowish in color). A review of the skin assessment notes completed on 5/13/12 stated "Bruises 1 cm (centimeters) x 0.5 cm to right temple greenish-yellowish in color and left outer chin/jaw 0.25 cm x 0.50 cm." In a family interview on 5/15/12 at 10:20 am, the relative indicated on 5/13/12 she noticed bruising to the face and side of the neck of Resident #4. She indicated she reported/discussed the concern with Nurse #1 that Resident #4 stated a facility staff hit her. The relative added Nurse #1 observed the bruising on Resident #4's face and Resident #4 stated in the presence of Nurse #1 that a facility staff hit her and Nurse #1 did not respond to the alleged statement regarding being hit by a facility staff, but indicated she would complete a skin assessment. In an interview on 5/15/12 at 12:37 pm, NA #1 indicated Resident #4 stated to him she was pistol whipped and he observed a yellow discoloration on the side of her face on 5/12/12 but did not think anything of the discoloration as it related to abuse; nor did he report the bruise to the nurse. NA #1 stated he was trained to report any alleged abuse allegation - but did not think of it as an abuse concern. NA #1 concluded he reported to Nurse #1 on 5/13/12 that a relative approached him related to the bruising, and was informed by Nurse #1 she was in route to Resident #4's room. In an interview on 5/15/12 at 1:07 pm, Nurse #1 who worked from 7 am - 7 pm on 5/13/12 revealed on 5/13/12 in the presence of Resident	F 225	2. A complete body audit of residents in the facility was performed. Interviews were conducted of alert and oriented residents by the social work team. All staff were re-educated on abuse and neglect, reporting on procedures either in person or via telephone by the DON/designee on 5/15/2012. 3. Monitor timeliness of abuse reporting and conduct random interviews with staff about abuse and neglect. 3x week for 3 months; then weekly x 4 weeks; monthly x2 months; quarterly x 2.	6-12-12 6-12-12.

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F 225	Continued From page 3 #4 and a relative, Resident #4 reported that she was pistol whipped by a female facility staff, but did not mention a staff name. Nurse #1 indicated she did not think of the concern as an abuse issue due to Resident #4's relative did not believe she was hit by a facility staff. Nurse #1 added she did not report the concern to administration, nor did she initiate an abuse allegation investigation - but completed a skin assessment, a grievance concern and placed the grievance form in the Director of Nursing (DON) facility mailbox. Nurse #1 added she initially put the wrong dated of 5/12/12 on the grievance form, and that the correct date was 5/13/12. Nurse #1 indicated because Resident #4 wore corrective lenses (glasses) she thought that the glasses may have contributed to the bruises. In an interview on 5/15/12 at 2:32 pm, the administrator revealed she was notified on 5/15/12 at approximately 10:30 am by the DON concerning the allegation made by Resident #4. She added she acknowledged that the alleged concern voiced by Resident #4 on 5/13/12, should have been reported to either the administrator, DON, or any administrative staff due to an allegation of abuse was made by Resident #4 on 5/13/12. She concluded the reason for notifying any administrative staff was to ensure an abuse investigation was initiated, and the appropriate state reports were completed. In an interview on 5/16/12 at 3:38 pm, the DON stated she became aware of the bruising observed on Resident #4 on 5/15/12 after the state agency departure for the day around 5:00 pm. She indicated the grievance form retrieved	F 225	4. Information will be reported to the QA committee and the administrator or designee monthly. DON/designee will be responsible for monitoring and reporting.	6-12-12

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F 225	Continued From page 4 from her mailbox did not indicate the resident was physically hit by a facility staff. The DON added she was not aware of any alleged physical allegations made by Resident #4 until 5/15/12 when approached by the state agency. The DON concluded her expectation was that the staff would immediately report such statements made by Resident #4 immediately to the administrative staff, so that an investigation could have been conducted and state reports initiated.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, and family interview, the facility failed to implement their policies and procedures to investigate, and report an allegation that a facility staff physically hit 1 of 1 sampled resident (Resident #4). Findings included: A review of the facility "Abuse Investigation" policy dated 10/26/10 in part read, "All abuse allegations will be reported and investigated according to responsibility and policy for abuse. The facility will investigate and report incidents or occurrences in accordance with federal and state regulations and guidelines. Outside investigative bodies, such as the police will be contacted as	F 226	F226 1. Once notified of the allegation in regards to resident #4 the facility completed a 24 hour report and 5 day investigation will follow at completion of investigation. The staff member that failed to notify facility of bruising to be given disciplinary action and re-education on 5/15/2012.	6-12-12

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F 226	Continued From page 5 directed by the administrator and in accordance with state and local law." A review of the facility "Reporting/Response" policy dated 10/26/10 in part read, "Report all alleged violations and all substantiated incidents to the state agency and to all other required agencies as required, and take all necessary corrective actions depending on the results of the investigation. Report to the state nurse aide or medication aide registry or licensing authority any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service. Report to law enforcement agencies as appropriate to the situation; analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences." Resident #4 was readmitted into the facility on 7/15/11. Diagnoses included Biploar, Dementia, Psychosis, Cerebrovascular Accident, Hemiplegia, and Hemiparesis. The most recent quarterly Minimum Data Set (MDS) completed on 4/12/12 indicated Resident #4 was cognitively intact. Disorganized thinking was indicated as present/fluctuated in that the behavior comes and goes and changes in severity. There was no indication of an acute onset mental status change. Behaviors included delusions and verbal behavior symptoms directed toward others. Rejection of care was indicated as occurred within 1 to 3 days of the MDS assessment. The MDS documented Resident #4, required extensive assistance with bed mobility and toileting. Transfers, dressing, eating and hygiene were indicated as occurred once or twice with one to two person assist.	F 226	2. A complete body audit of residents in the facility was performed. Interviews were conducted of alert and oriented residents by the social work team. All staff were re-educated on abuse and neglect reporting procedures either in person or via telephone on 5/15/2012.	6-12-12

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F 226	Continued From page 6 A review of the facility's receipt of concern (grievance) completed on 5/12/12 (corrected date is 5/13/12 per Nurse #1 interview on 5/15/12 at 1:07 pm) revealed a written concern initiated by Resident #4's relative. Documentation indicated the relative notified Nurse #1 of two bruises to Resident #4's face (right temple, left jaw - yellowish in color). A review of the skin assessment notes completed on 5/13/12 stated "Bruises 1 cm (centimeters) x 0.5 cm to right temple greenish-yellowish in color and left outer chin/jaw 0.25 cm x 0.50 cm." A review of the nurses' notes from April 1, 2012 through May 18, 2012 revealed no documentation wherein, Resident #4 was physically aggressive toward the staff during care. Nurses' notes regarding behaviors on 5/14/12 at 3:20 pm indicated Resident #4 "Refused care and was verbally abusive at times." In a resident interview on 5/15/12 at 9:55 am, Resident #4 stated she was hit in the face this week by a nurse aide who worked first shift for no unknown reason. Resident #4 indicated she did not know the staff name, but the staff was a female. Resident #4 added the nurse aide told her if she reported what happened to anyone, she would hit her again. Resident #4 stated she was afraid and did not report what had happened to anyone, and that her face hurt. Resident #4 indicated that a relative observed the bruises on her face and neck upon visit on 5/13/12 and that she informed her relative what had happened. Resident #4 stated her relative did not believe her. She concluded that she was still afraid that	F 226	3. Monitor timeliness of abuse reporting and conduct random interviews with staff about abuse and neglect. 3x week for 3 months; then weekly x 4 weeks; monthly x2 months; quarterly x 2.	6-12-12

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F 226	Continued From page 7 the nurse aide would return, but the nurse aide had not been in her room since. On 5/15/12 at 10:09 am, Resident #4 was observed with a greenish-yellowish skin bruise to the right side of her face in the temple area and a greenish-yellowish skin bruise to the left side of her neck (below the chin area). Resident #4 was positioned in the bed in a comfortable position on her back without any hazardous items observed, while in bed. Her eye glasses were position on her face with no concerns. In a family interview on 5/15/12 at 10:20 am, the relative indicated on 5/13/12 she noticed bruising to the face and side of the neck of Resident #4. She indicated she reported/discussed the concern with Nurse #1 that Resident #4 stated a facility staff hit her. The relative added Nurse #1 observed the bruising on Resident #4's face and Resident #4 stated in the presence of Nurse #1 that a facility staff hit her (no specific names mentioned) and Nurse #1 did not respond to the alleged statement regarding being hit by a facility staff, but indicated she would complete a skin assessment. The relative added she did not believe Resident #4 was hit by a facility staff. In a telephone interview on 5/15/12 at 11:30 am, NA #2 who worked 3 pm - 7 am on 5/12/12 and 5/13/12, NA #2 stated he did not observed, nor did he receive a report of concerns during shift report that Resident #4 was allegedly hit or bruised. In an interview on 5/15/12 at 12:37 pm, NA #1 indicated Resident #4 stated to him she was pistol whipped and he observed a yellow	F 226		

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F 226	Continued From page 8	F 226		

discoloration on the side of her face on 5/12/12 but did not think anything of the discoloration as it related to abuse; nor did he report the bruise to the nurse. NA #1 stated he was trained to report any alleged abuse allegation - but did not think of it as an abuse concern. NA #1 stated he reported to Nurse #1 on 5/13/12 that a relative approached him related to the bruising, and was informed by Nurse #1 that she was in route to Resident #4's room. NA #1 indicated Resident #4 required assistance from the staff with activities of daily living and was willing to assist during care. He concluded he had not observed Resident #4 being resistant or fighting at the staff during her care.

In an interview on 5/15/12 at 1:07 pm, Nurse #1 who worked from 7 am - 7 pm on 5/13/12 revealed on 5/13/12 in the presence of Resident #4 and a relative, Resident #4 reported that she was pistol whipped by a female facility staff, but did not mention a staff name. Nurse #1 indicated she did not think of the concern as an abuse issue due to Resident #4's relative did not believe she was hit by a facility staff. Nurse #1 added she did not report the concern to administration, nor did she initiate an abuse allegation investigation - but completed a skin assessment, a grievance concern and placed the grievance form in the Director of Nursing (DON) facility mailbox. Nurse #1 added she initially put the wrong dated of 5/12/12 on the grievance form, and that the correct date was 5/13/12. Nurse #1 indicated because Resident #4 wore corrective lenses (glasses) she thought that the glasses may have contributed to the bruises. Nurse #1 concluded she could not recall for certain if she reported to the oncoming nurse regarding Resident #4's

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F 226	Continued From page 9 statement of being hit by a facility staff, or the observed bruises. In a telephone interview on 5/15/12 at 1:30 pm, Nurse #3 who worked 7 pm - 7 am on 5/12/12, 5/13/12, stated he did not observe any bruising, nor did he receive shift report that indicated Resident #4 was hit by a facility staff. In an interview on 5/15/12 at 2:32 pm, the administrator revealed she was notified on 5/15/12 at approximately 10:30 am by the DON concerning the allegation made by Resident #4. She added she acknowledged that the alleged concern voiced by Resident #4 on 5/13/12, should have been reported to either the administrator, DON, or any administrative staff due to an allegation of abuse was made by Resident #4 on 5/13/12. She concluded the reason for notifying any administrative staff was to ensure an abuse investigation was initiated, and the appropriate state reports were completed. In an interview on 5/16/12 at 3:38 pm, the DON stated she became aware of the bruising observed on Resident #4 on 5/15/12 after the state agency departure for the day around 5:00 pm. She added she notified the social worker and the abuse investigation was initiated. The DON indicated the grievance form retrieved from her mailbox did not indicate the resident was physically hit by a facility staff. The DON added she was not aware of any alleged physical allegations made by Resident #4 until 5/15/12 when approached by the state agency. The DON concluded her expectation was that the staff would have reported such statements made by	F 226	4. Information will be reported to the QA committee and the administrator or designee monthly. DON/designee will be responsible for monitoring and reporting.	6-12-12

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F 226	Continued From page 10 Resident #4 immediately to the administrative staff, so that an investigation could have been conducted and state reports initiated.	F 226		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

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F 431	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to remove expired intravenous therapy solution bags to prevent possible usage from 1 of 4 medication rooms (400 hall med storage room). Findings included: A review of the facility policy titled "Storage of Medication" (undated) read in part, "Outdated, contaminated, or deteriorated medication and those in containers that are cracked, soiled, or without secure closures are immediately removed from use; disposed of according to procedures for medication disposal; and reordered from the pharmacy; if a current order exists." On 5/17/12 at 9:15 am accompanied by Nurse #2 (unit coordinator) during an observation of the 400 hall medication storage room revealed the following expired items mixed together in a black tote box (not labeled) with non-expired intravenous therapy solutions bags within as follow: · One 0.45 % NACL (sodium chloride) 1000 milliliters (ml) bag with an expired date of March 2012 · One 0.9 % NACL 500 ml bag with an expired date of April 2012 In an interview on 5/17/12 at 9:45 am, Nurse #4 who worked on the 400 hall when asked where she would go to obtain intravenous (IV) solution	F 431	F431 1. The items found to be in question on 5/17/12 were removed from the area immediately. 2. In-service will be completed by the Director of Nursing or designee on IV house stock storage and returning process of expired IV meds to the pharmacy.	6-12-12 6-12-12

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(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 431	Continued From page 12 to be administered to residents' if ordered by the physician replied "The med storage room." On 5/17/12 at 9:47 am, Nurse #4 walked into the 400 hall medication storage room (accompanied by Nurse #2 unit coordinator), reached into the black tote box that was located in the floor, removed one bag of IV solution, then indicated she would thereafter, administer the IV solution to the resident as ordered by the physician. There was no signage observed on the black tote box that indicated or alerted the staff, that expired and non-expired IV solution bags were located inside together. In an Interview on 5/17/12 at 11:43 am, the Director of Nursing stated she expected the IV solution bags to have been discarded to prevent the potential of usage.	F 431	3. Pharmacy consultant will monitor on monthly visits for a period of 3 months to ensure compliance is maintained. The consultant will report findings to the DON/designee who will monitor and report to the QA committee. 4. The QA process will be reviewed during monthly QA for a period of 3 months. The Director of Nursing or designee will be responsible to report to the QA committee.	6-12-12 6-12-12 6-12-12

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345434	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 5/18/2012

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	F157 (no plan required)
F 157	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on record review, staff interviews, and family interview, the facility failed to notify the designated legal representative regarding bruises for 1 of 1 sampled resident (Resident #4).

Findings included:

Resident #4 was readmitted into the facility on 7/15/11. Diagnoses included Biploar, Dementia, Psychosis, Cerebrovascular Accident, Hemiplegia, and Hemiparesis. The most recent quarterly Minimum Data Set (MDS) completed on 4/12/12 indicated Resident #4 was cognitively intact. Disorganized thinking was indicated as present/fluctuated in that the behavior comes and goes and changes in severity. There was no indication of an acute onset mental status change. Behaviors included delusions and verbal behavior symptoms directed toward others. Rejection of care was indicated as occurred within 1 to 3 days of the MDS assessment. The MDS documented Resident #4, required extensive assistance with bed mobility and toileting. Transfers, dressing, eating and hygiene were indicated as occurred once or twice with one to two person assist.

A review of the facility's receipt of concern (grievance) completed on 5/12/12 (corrected date is 5/13/12 per Nurse #1 interview on 5/15/12 at 1:07 pm) revealed a written concern initiated by Resident #4's relative. Documentation indicated the relative notified Nurse #1 of two bruises to Resident #4's face (right temple, left jaw - yellowish in color).

In a family interview on 5/15/12 at 10:20 am, the relative indicated on 5/13/12 she noticed bruising to the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 157	Continued From Page 1

face and side of the neck of Resident #4 that she was unaware of. She indicated she reported/discussed the concern while at the facility with Nurse #1 and inquired why she was not notified by the facility regarding the bruises. The relative stated Nurse #1 responded that she would complete a skin assessment that was due on 5/11/12, a grievance form - and leave in the Director of Nursing facility mailbox.

In an interview on 5/15/12 at 12:37 pm, NA #1 stated he observed a yellow discoloration on the side of Resident #4's face on 5/12/12, but did not report it to the nurse - due to he did not see it as a concern. NA #1 stated he reported to Nurse #1 on 5/13/12 that a relative approached him related to the bruising, and was informed by Nurse #1 she was in route to Resident #4's room.

In an interview on 5/16/12 at 3:38 pm, the DON stated she became aware of the bruising observed on Resident #4 on 5/15/12 after the state agency departure for the day around 5:00 pm. The DON stated her expectation was that the skin assessment should have been completed as scheduled on 5/11/12. She concluded she expected the legal representative to have been notified as soon as possible, upon observation of the bruise.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/07/2012

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
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Thursday 6/6/12 at approximately 9:15 AM onward the following was noted: 1) The corridor door to the boiler room located on 200 hall was not self closing. Doors are to be self-closing and close, latch and seal. 2) Resident at the end of 200 hall is used for tempory storage nad is not equipped with self closing device.	K 029	Carver Living Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the Summary of Findings is factually correct in order to maintain compliance with applicable rules and the provision of quality care to residents. The plan of correction is submitted as a written allegation of compliance. Carver Living Center's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute and admission that any stated deficiencies is accurate. Carver Living Center reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceeding or any administrative or legal proceedings. 1. An automatic closer was installed on the door to the boiler room on the 200 hall. 2. The resident room at the end of 200 hall was cleaned and storage items removed and returned to its original function as a resident room. 3. The maintenance director or designee will monitor once a week for 3 months to ensure compliance is maintained. 4. Maintenance director/designee will report their findings to the QA committee for 3 months to ensure compliance is maintained.	6-15-12 6-15-12
K 056 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the	K 056	See attached waiver request.	8-13-13

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

administrator 6/28/12

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/07/2012

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K 056	Continued From page 1 Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Thursday 6/6/12 at approximately 9:15 AM onward the following was noted: 1) There are resident rooms throughout the area that have alcoves with some of the alcoves having furniture located within them. These alcoves are located on the same side of the room as the wall mounted sprinkler. Facility must provide documentation from a certified sprinkler designer that the existing heads will provide coverage into the alcoves or install additional sprinkler coverage to these areas. 42 CFR 483.70(a)	K 056	See attached waiver	8-13-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING 02 - BUILDING 02 B. WING _____	06/07/2012

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K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Thursday 6/6/12 at approximately 9:15 AM onward the following was noted: 1) The storage room located next to the vending machines on 400 hall was not self-closing. 2) The ceiling in the mechanical room accessible from the employee smoke area has holes and penetration in the ceiling around the exhaust vent that was not sealed in order to maintain the required fire resistance rating of the room. 42 CFR 483.70(a)	K 029	1. An automatic closer was installed on the door to the storage room next to the 400 hall vending machines. 2. Ductwork in ceiling and walls of mechanical room were sealed to meet required fire resistance. 3. The corrective action will be monitored by maintenance director/designee once a week for 3 months. 4. The corrective action will be monitored by the QA committee. This will be monitored by the maintenance director/designee and reported to the committee for a period of 3 months.	6-15-12 6-15-12
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 056	See attached waiver	8-13-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	administrator	6/28/12

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