APR 3 0 2013

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

PRINTED: 04/04/2013
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 ______ | C 03/20/2013 |

| 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<br><br>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.<br><br>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).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>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 | THIS RESPONSE AND PLAN OF CORRECTION IS BEING SUBMITTED PURSUANT TO THE APPLICABLE FEDERAL AND STATE REGULATIONS. NOTHING CONTAINED HEREIN SHALL BE CONSTRUED AS AN ADMISSION THAT THE FACILITY VIOLATED ANY FEDERAL OR STATE REGULATION, OR FAILED TO FOLLOW ANY APPLICABLE STANDARD OF CARE. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 4/26/13

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 |
|---|---|---|---|
| | 346434 | A. BUILDING ______ B. WING ______ | C 03/20/2013 |

| 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 | Continued From page 1<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to thoroughly investigate an allegation of resident abuse for 1 of 2 sampled residents (Resident #3) and failed to submit a 5 day report of an allegation of resident abuse to the Health Care Personnel Registry for 1 of 2 sampled residents (Resident #4). The findings included:<br><br>1. Resident #3 was admitted into the facility on 1/9/12. The admission minimum data set completed on 1/21/13 indicated Resident #3 cognitive status was severely impaired.<br><br>A review of the 5 day working report signed on 3/6/13 by the social worker revealed an allegation of resident abuse that read in part"Resident #3 states that an aide is handling him roughly and threw him on the bed. He also stated that the aide was pulling on his clothing. Unable to recall date or the description of the person he was alleging."<br><br>A review of unit manger (UM) #2 investigation report of the allegation signed on 3/6/13 indicated as part of the investigation she talked to Resident #3, and that Resident #3 could not give an accurate description of the alleged person, nor could he recall the time of day the incident occurred. The investigation concluded when Resident #3 was questioned by UM #2 if any one had been rough with or hit him? He replied no. There was no additional investigation material for review from the date that UM #2 signed the investigation as completed on 3/6/13. | F 225 | F 225<br><br>1. Investigation for residents #3 has been reviewed and is completed thoroughly. 5 day follow up report for resident #4 is completed and submitted to the Health Care personnel registry.<br>2. A review of investigations including policies and procedures that prohibit mistreatment, neglect, abuse and misappropriation of resident property will be conducted to ensure no other residents have been affected. A review of reportable investigations will be conducted to ensure timely reporting is in place. | |

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 ______ B. WING ______ | C 03/20/2013 |

| 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 | Continued From page 2<br>In an interview on 3/19/13 at 3:40 pm, UM #2 acknowledged the investigation report signed on 3/6/13 that read in part "Resident #3 alleged that a staff member was rough with him during the initial conversation, Resident #3 could not give an accurate description of the person. Resident #3 also could not recall the time of day the incident occurred. During the follow up conversation Resident #3 stated he did not know what I (UM #2) was talking about, when asked if anyone had been rough with him or had hit him, he replied no" was her investigation of the alleged allegation.<br><br>In an interview on 3/20/13 at 9:48 am, the administrator (accompanied by the director of nursing (DON) stated that he was the abuse coordinator. He indicated that he expected UM #2's investigation to have included other residents, staff members that were interviewed, and any education/in-services that was provided to the staff since the allegation, as part of the investigation.<br><br>2. Resident #4 was admitted into the facility on 11/22/11. The quarterly minimum data set completed on 12/28/12 indicated Resident #4 cognitive status was moderately impaired.<br><br>A review of the 24 hour initial report submitted to the healthcare personnel registry (HCPR) by the social worker on 12/21/12 revealed an allegation of resident abuse. UM #2 investigation statement dated 12/21/12 that was attached to the 24 hour report indicated that Resident #4 relative reported to her on the telephone, that Resident #4 had informed the relative that the aides were rough with her and tried to force her to put clothes on. As a result, Resident #4 fought the aides back. | F 225 | 3. In-service education will be conducted by the Administrator and or designee to leadership staff to ensure investigation expectations and policies and procedures on investigating and reporting is clear and compliance is achieved. Education will be provided to staff by the Administrator and or designee to staff to ensure the policy and procedure that prohibit mistreatment, neglect, abuse and misappropriation of resident property to ensure compliance with this requirement. | |

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

PRINTED: 04/04/2013
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 ______ | C 03/20/2013 |

| 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 | Continued From page 3<br>UM #2's statement indicated upon her entry into the room Resident #4 reported to UM #2 that three nursing assistants tried to force her to go to the bathroom, and that she fought the nursing assistants back because they were fighting her.<br><br>A review of the investigation revealed no 5 day report submitted to the HCPR.<br><br>In an interview on 3/20/13 at 9:48 am, the administrator (accompanied by the DON) stated he expected the 5 day report to have been submitted to the state agency.<br><br>In an interview on 3/20/12 at 4:35 pm, the social worker indicated that she faxed the 5 day report to the state agency within the allotted time requirement.<br><br>In an interview on 3/21/12 at 2:10 pm, the HCPR staff confirmed that there was no record that a 5 day report was faxed by the facility. | F 225 | 4. On-going monitoring of investigation and reporting procedures will be conducted for 90 days to ensure compliance with this requirement. Findings will be reported to the Quality Assurance committee for review. Policy and procedure that prohibit mistreatment, neglect, abuse and misappropriation of resident property will be reviewed to ensure meets this requirement. | 4/17/13 |
| F 226 SS=D | 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to implement their policy for submitting a 5 day report of an allegation of abuse to the Health Care Personnel Registry for | F 226 | | |

| 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 ______ | C 03/20/2013 |

| 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 226 | Continued From page 4<br>1 of 2 sampled residents (Resident #4) and failed to implement their policy for thoroughly investigating an allegation of abuse for 1 of 2 sampled residents (Resident #3). The findings included:<br><br>A review of the facility's policy for reporting alleged resident abuse dated January 2009 read in part "A written report must be sent to Health Care Personnel Section, within five [5] working days of the date the facility becomes aware of the alleged incident."<br><br>1. Resident #4 was readmitted into the facility on 11/22/11. The quarterly minimum data set completed on 12/28/12 indicated Resident #4 cognitive status was moderately impaired.<br><br>A review of the 24 hour initial report submitted to the healthcare personnel registry (HCPR) by the social worker on 12/21/12 revealed an allegation of resident abuse. Unit Manager (UM) #2 investigation statement dated 12/21/12 that was attached to the 24 hour report dated 12/21/12 indicated that Resident #4 relative reported over the telephone to UM #2, that Resident #4 had informed the relative that the aides were rough with her and tried to force her to put clothes on. As a result, Resident #4 fought the aides back. UM #2's statement indicated upon her entry into the room Resident #4 reported to UM #2 that three nursing assistants tried to force her to go to the bathroom, and that she fought the nursing assistants back because they were fighting her.<br><br>A review of the investigation revealed no 5 day report submitted to the HCPR. | F 226 | F 226<br><br>1. Investigation for residents #3 has been reviewed and is completed thoroughly. 5 day follow up report for resident #4 is completed and submitted to the Health Care personnel registry.<br>2. A review of investigations including policies and procedures procedure that prohibit mistreatment, neglect, abuse and misappropriation of resident property will be conducted to ensure no other residents have been affected. A review of reportable investigations will be conducted to ensure timely reporting is in place. | |

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 ______ B. WING ______ | C 03/20/2013 |

| 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 226 | Continued From page 5<br>In an interview on 3/20/13 at 9:48 am, the administrator (accompanied by the DON) stated he expected the 5 day report to have been submitted to the state agency per the facility abuse policy.<br><br>In an interview on 3/20/12 at 4:35 pm, the social worker indicated that she faxed the 5 day report to the state agency within the allotted time requirement. The SW indicated no specific date that the report was faxed.<br><br>In an interview on 3/21/12 at 2:10 pm, the HCPR staff confirmed that there was no record that a 5 day report was faxed by the facility.<br><br>A review of the facility's policy for investigating alleged resident abuse dated May 2010 read in part "Allegations of abuse must be investigated thoroughly. Interview person/persons submitting complaint and/or witnesses (also potential witnesses). Obtain written statements and statement from complainant. Interview all other staff members as appropriate (one employee, one hall, one shift, all shifts, as dictated per situation), Interview room mate as appropriate."<br><br>2. Resident #3 was admitted into the facility on 1/9/12. The admission minimum data set completed on 1/21/13 indicated Resident #3 cognitive status was severely impaired.<br><br>A review of the 5 day working report signed on 3/6/13 by the social worker revealed an allegation of resident abuse that read in part "Resident #3 states that an aide is handling him roughly and threw him on the bed. He also stated that the aide was pulling on his clothing. Unable to recall date | F 226 | 3. In-service education will be conducted by the Administrator and or designee to leadership staff to ensure investigation expectations and policies and procedures on investigating and reporting is clear and compliance is achieved. Education will be provided to staff by the Administrator and or designee to staff to ensure the policy and procedure that prohibit mistreatment, neglect, abuse and misappropriation of resident property to ensure compliance with this requirement. | |

| 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 ______ | C 03/20/2013 |

| 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 226 | Continued From page 6<br>or the description of the person he was alleging."<br><br>A review of unit manger (UM) #2 investigation report of the allegation signed on 3/6/13 indicated as part of the investigation she talked to Resident #3, and that Resident #3 could not give an accurate description of the alleged person, nor could he recall the time of day the incident occurred. The investigation concluded when Resident #3 was questioned by UM #2 if any one had been rough with or hit him? He replied no. There was no additional investigation material for review from the date that UM #2 signed the investigation as completed on 3/6/13.<br><br>In an interview on 3/19/13 at 3:40 pm, UM #2 acknowledged the investigation report signed on 3/6/13 that read in part "Resident #3 alleged that a staff member was rough with him during the initial conversation, Resident #3 could not give an accurate description of the person. Resident #3 also could not recall the time of day the incident occurred. During the follow up conversation Resident #3 stated he did not know what I (UM #2) was talking about, when asked if anyone had been rough with him or had hit him, he replied no" was her investigation of the alleged allegation.<br><br>In an interview on 3/20/13 at 9:48 am, the administrator (accompanied by the director of nursing (DON) stated that he was the abuse coordinator. He indicated that he expected UM #2's investigation to have included other residents, staff members that were interviewed, and any education/in-services that was provided to the staff since the allegation, as part of the investigation. | F 226 | 4. On-going monitoring of investigation and reporting procedures will be conducted for 90 days to ensure compliance with this requirement. Findings will be reported to the Quality Assurance committee for review. Policy and procedure that prohibit mistreatment, neglect, abuse and misappropriation of resident property will be reviewed to ensure meet this requirement. | 4/17/13 |
| F 323 | 483.25(h) FREE OF ACCIDENT | F 323 | | |

| 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 ___ | C 03/20/2013 |

| 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 323 SS=D | Continued From page 7<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interviews and record review, the facility failed to have 2 staff providing care and evaluate the details of the fall so that effective interventions could be put in place to prevent further falls from the bed in one of three residents (resident #1) reviewed.<br>Findings included:<br><br>Resident #1 was admitted to the facility on 11/15/12 with diagnosis of quadriplegia and seizures.<br><br>A review of resident #1's quarterly Minimum Data Set (MDS) dated 2/25/13 indicated that he was cognately intact with no behaviors and he had one fall with no injury. This MDS also indicated that resident #1 required total assistance with 2 staff for bed mobility, transfers, toileting and bathing.<br><br>A review of resident #1's care plan initiated 11/27/12 indicated the need for total assistance of 2 staff for bed mobility, transfers, toileting and bathing. There was a care plan for falls dated 11/27/12 and updated 1/28/13 to include 2 staff | F 323 | F 323<br><br>1. Resident #2 is receiving assistance by two staff members and the details of any falls are being evaluated to ensure appropriate interventions are in place to prevent further incidents.<br>2. A comprehensive review of residents at risk for falls to be conducted by 4/12/13 to ensure appropriate interventions and assistance is in place to prevent falls. Appropriate and comprehensive plan of care will be updated to prevent further falls. | |

| 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 ______ | C 03/20/2013 |

| 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 323 | Continued From page 8<br>assistance for transfers and floor mats at the bedside.<br><br>A review of the incident report dated 1/25/13 indicated that one aide was performing resident #1's activities of daily living (ADL's) in the bed when he experienced a muscle spasm. Interventions included floor mats at bedside and 2 person assist during his ADL care. The incident report did not indicate that resident #1 had any complaints of pain and there was no apparent injury on assessment. The report indicated there was a witness present and that the resident was not interviewed at the time of the fall.<br><br>A review of the physician's progress note dated 1/25/13 indicated that resident #1 complained of left shoulder and left hip pain. There was no swelling or deformity of the left hip or left shoulder. X-Rays were ordered and both were negative for evidence of fracture.<br><br>A review of the nursing notes from 1/26/13 to 1/29/13 did not reveal any noted concerns related to the fall except for some voiced pain to his left shoulder and left hip.<br><br>On 3/20/13 at 10:20 AM, resident #1 was observed sitting up in bed. He was experiencing a muscle spasm to his left hand. He stated he just took medication for relief.<br><br>On 3/20/13 at 11:30 AM, the nursing unit manager #1 stated the floor nurse completed the incident report and she completed the quality assurance form on the fall. She stated all falls were discussed in the morning meetings and on this occasion, mats were added to the bed side | F 323 | 3. Education to staff to be completed by Director of Nursing and or designee to ensure residents in need of assist of 2 or more are receiving appropriate assistance; and education on preventing residents at risk for falls not being left unattended to assure compliance with this requirement.<br><br>4. On-going monitoring of fall prevention interventions to be completed for 90 days to ensure compliance with this requirement. Findings will be reported to the QA committee for review. | 4/17/13 |

| 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 ______ | C 03/20/2013 |

| 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 323 | Continued From page 9<br>and resident #1 was changed to a 2 person assist for his ADL's. The nursing unit manager #1 stated she did not notice the witness indicated on the incident report nor did she notice that resident #1 was not questioned. The nursing unit manager #1 stated that at the time of the fall, she thought that the resident was a 2 person assist for transfers only.<br><br>On 3/20/13 at 11:50 AM, nursing assistant (NA) #1 stated she was the NA assisting resident #1 on 1/25/13 at the time of his fall. She stated she completed his bath and ADL care alone. NA #1 stated she left resident #1 in the middle of the bed to go to the doorway to get someone to help her get resident #1 out of the bed. NA #1 stated resident #1 had a spasm and fell off the bed. NA #1 could not recall if she lowered the bed or put his side rail up when she left the bedside. NA #1 stated she thought resident #1 was a 2 person assist for transfers only. NA #1 stated the staff was to follow the care plan in the computer to know how to care for each resident.<br><br>On 3/20/13 at 11:55 AM, the MDS nurse stated that the aides follow the care plan in the computer to know how to care for each resident. The MDS nurse stated she updated the fall care plan on 1/28/13 to include the floor mats and 2 staff assist for his ADL's but did not realize he was already care planned for 2 staff assistance on the ADL care plan.<br><br>On 3/20/13 at 1:20 PM, resident #1 stated that NA #1 had given him a bath and left him on the edge of the bed when she went to get help to get him up out of the bed. Resident #1 stated his alternating air mattress deflated and he suddenly | F 323 | | |

| 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 ______ | C 03/20/2013 |

| 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 323 | Continued From page 10<br>had a spasm. He stated he fell from the bed onto the floor. He stated the bed was not in the low position and his side rail was not engaged. He stated he was not injured.<br><br>On 3/20/13 at 1:30 PM, the director of nursing (DON) stated she was aware that NA #1 was in the room doing ADL care at the time of the incident. She stated she was told during the morning meeting that resident #1 was on his side and slid off the other side of the bed due to a spasm. She indicated she thought NA #1 witnessed the fall and was not aware that NA #1 left resident #1 on the bed unattended while she went to the doorway to call for help.<br><br>On 3/20/13 2:20 PM, NA #2 stated she was called to the room by NA #1 and witnessed resident #1 lying on the floor. She stated she got the nurse and resident #1 was assessed before he was moved. She stated she worked with resident # 1 on several occasions and would always get assistance when she would bathe or toilet him because he was so stiff in his joints and that he would sometimes have spasms where he could not control his movements. NA #2 stated she followed the care plan in the computer to know how to care for her assigned resident's.<br><br>On 3/20/13 at 3:15 PM, the DON stated she attempted to contact the nurse assigned resident #1 at the time of the fall on 1/25/13 but she was unavailable for interview. The DON stated her expectation would be for 2 staff present during resident #1's ADL care and transfers. The DON stated resident #1 should not be left unattended in the time of the fall. | F 323 | | |

| 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 ______ | C 03/20/2013 |

| 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 323 | Continued From page 11<br>On 3/25/13 at 10:14 AM, nurse #2 stated on the day of the fall, NA #2 approached her at her medication cart and stated resident #1 was on floor. Upon entering the room, NA #1 stated she rolled resident #1 over to wash him and he experienced a spasm. He rolled off the bed onto the floor between the wall and bed. Nurse #2 stated resident # 1 was lying on his side and had no complaints of pain. He wanted to be gotten up off floor to go outside to smoke. Nurse #2 stated that resident #1 stated he had a spasm and rolled off the bed. | F 323 | | |