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 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	**303 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
E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 10/28/20 to 10/30/20, 11/2/20, and 11/5/20 to 11/6/20. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# YJ5N11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 10/28/20 to 10/30/20, 11/2/20, and 11/5/20 to 11/6/20. The facility was found in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event # YJ5N11 Two of the five complaint allegations were substantiated resulting in a deficiency. Past noncompliance was identified at: CFR 483.45 at tag F 760 at a scope and severity K. The tag F 760 constituted Substandard Quality of Care. A partial extended survey was conducted.	F 000		
F 760 SS=K	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	F 760		11/18/20

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

Electronically Signed | 11/18/2020

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 _____ B. WING _____	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 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 760	Continued From page 1 by: Based on record review, staff interviews, physician assistant interview, nurse practitioner interview, and physician interviews, the facility failed to administer insulin and perform glucose monitoring for one (Resident #1) of three residents reviewed for significant medication errors. The facility failed to transcribe orders for insulin and blood glucose monitoring resulting in a hospital admission for Resident #1 for diabetic ketoacidosis (Diabetic ketoacidosis is a severe and life-threatening complication of diabetes.) Finding include: Resident #1 had diagnoses of Type 2 insulin diabetes mellitus and heart disease. Resident #1 was admitted to the facility on 9/22/20 from the hospital status post coronary artery bypass graft and aortic valve replacement surgery. Documentation on a hospital discharge summary, printed by the facility on 9/22/20, listed current discharge medications for Resident #1 for the treatment of diabetes. One of the orders was for insulin Novolog Mix Flexpen 70/30 100 unit/milliliter (ml) pen to be administered as an injection of 28 units before breakfast and 28 units before dinner. Another order was for Metformin 500 milligram (mg) tablet to be administered as two tablets (1,000 mg) by mouth two times daily with meals. Metformin is an oral diabetes medicine that helps control blood sugar levels. An additional order requested glucose monitoring before meals and at bedtime. Documentation on the baseline care plan completed on 9/22/20 revealed Resident #1 had Diabetes and was prescribed insulin.	F 760	Past noncompliance: no plan of correction required.	

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 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 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 760	Continued From page 2	F 760		

Documentation on the physician orders in the electronic health record from 9/22/20 to 10/5/20 for Resident #1 listed the physician order for administration of Metformin but did not have orders for insulin or glucose monitoring. Documentation on an admission physician's progress note dated 9/22/20 revealed Resident #1 was noted to have a diagnosis of insulin dependent diabetes mellitus and to be receiving insulin. Documentation in the plan portion of the physician's progress note stated that for the diagnosis of insulin dependent diabetes mellitus, the resident would receive monitoring of blood glucose levels along with metformin, insulin and a reduced concentrated sweet diet.

Documentation on an Admission Medicare 5-Day Minimum Data Set assessment completed on 9/26/20 coded Resident #1 as cognitively intact and receiving no insulin injections and no insulin during the assessment period.

Documentation on the Medication Administration Record (MAR) revealed Resident #1 did not receive any insulin from admission 9/22/20 to discharge on 10/5/20. Documentation on the MAR revealed Resident #1 did receive Metformin as ordered from 9/22/20 to 10/5/20. Documentation on the MAR did not reveal any routine blood glucose monitoring but the electronic health record revealed one blood glucose was taken on 10/4/20 with a reading of 92.0 mg/dl (deciliter). (A normal blood glucose level is in the range of 80-100 mg/dl.)

Review of the nursing progress notes did not reveal any signs or symptoms of hypoglycemia or hyperglycemia for Resident #1 during his stay in

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 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 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 760	Continued From page 3	F 760		

the facility. Documentation in a nursing progress note dated 10/5/20 stated, "Resident was sent out to MD (medical doctor) appointment. From appointment resident was transferred to the ER (emergency room) [due to] suspected atrial fibrillation." Atrial fibrillation is an irregular heart beat that often causes the heart to beat too quickly.

Documentation in a hospital record revealed Resident #1 was taken to the emergency room on 10/5/20 and found to be in diabetic ketoacidosis. Resident #1 was admitted to the intensive care unit with the principle problem of diabetic ketoacidosis without coma associated with Type 2 diabetes mellitus. Documentation of initial laboratory values taken on 10/5/20 at 12:58 PM stated Resident #1 had a blood glucose level of 821 mg/dl. Resident #1 stayed in the hospital until 10/24/20 until his blood glucose levels returned to normal levels with aggressive treatment. Documentation of laboratory values taken on 10/24/20 at 11:44 AM stated Resident #1 had a blood glucose level of 88 mg/dl.

An interview was conducted with Nurse #2 on 11/5/20 at 10:47 AM. Nurse #2 explained the process for entering the physician orders into the electronic health record for Resident #1. Nurse #2 stated that the discharge summary from the hospital was printed, given to the facility physician or Nurse Practitioner (NP) for review/approval, and then entered by a nurse into the electronic health record. Nurse #2 indicated that the orders were then supposed to be checked by another nurse for accuracy in the electronic health record prior to the resident's arrival at the facility.

An interview was conducted with NP #1 on

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 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 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 760	Continued From page 4	F 760		

11/5/20 at 11:20 AM. NP #1 revealed that she was the one who reviewed and approved the medications on the hospital discharge summary for Resident #1 as evidenced by her initials and the date 9/22/20. NP #1 stated that the orders for the insulin and the glucose monitoring should have been put into the electronic health record after her approval of the orders was given.

An interview was conducted with Nurse #1, the unit manager, on 11/5/20 at 12:00 PM. Nurse #1 revealed that she was the one who put the physician orders into the electronic medical record for Resident #1 prior to admission. Nurse #1 stated she did not put the orders for the insulin and glucose monitoring into the electronic health record on 9/22/20 after NP #1 approved the medications on the hospital discharge summary. Nurse #1 stated she remembered entering the medications in to the computer in between passing medications on two medication carts and doing her charting on the residents on the halls. Nurse #1 stated usually she would check off the medications as she put them in and go down the list in order but on that day, she was interrupted multiple times by requests from the therapy department, a resident who wanted pain medication, processing two residents who were discharging that day in addition to multiple admissions. Nurse #1 acknowledged that usually one of the unit managers would go behind her and check the orders usually a day or so after orders were entered in the electronic health record. Nurse #1 indicated she had been working 7:00 AM to 7:00 PM, 12-hour shifts, in the capacity as a medication nurse and the unit manager for 7 days in a row prior to the day of the admission of Resident #1.

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 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 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 760	Continued From page 5	F 760		

An interview was conducted on 11/5/20 at 2:28 PM with the physician (MD #1) for Resident #1 who wrote the admission progress note on 9/22/20. MD #1 stated that he reviewed the hospital discharge summary and wrote his progress note for Resident #1 based on the orders and information he obtained from that discharge summary. MD #1 stated he found it surprising that Resident #1 was admitted to the hospital with diabetic ketoacidosis due to the facility taking a blood glucose level on 10/4/20 within the normal range, days prior to the resident's hospitalization.

An interview was conducted with the Director of Nursing (DON) on 11/5/20 at 6:49 PM. The DON stated that Nurse #1 was called into her office to discuss why the order for insulin and blood glucose monitoring was not put into the electronic health record of Resident #1. The DON stated that Nurse #1 had been working a lot of hours prior to the admission of Resident #1. The DON revealed it was the facility policy to use the unit managers and supervisors as floor nurses when a nurse was not available to work the shift.

An interview was conducted on 11/6/20 at 9:57 AM with the physician's assistant (PA #1) who saw Resident #1 in the post operation clinic on 10/5/20. PA #1 stated that when she entered the room to see Resident #1, she saw that he was short of breath, altered, incoherent, and in acute distress. PA #1 stated that laboratory values were taken at the clinic but Resident #1 was sent to the emergency room prior to obtaining the results. PA #1 stated the results revealed Resident #1 was in diabetic ketoacidosis and had a blood glucose level of 804 mg/dl taken at the clinic. PA #1 stated that not giving Resident #1 insulin for 14 days and

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 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 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 760	Continued From page 6	F 760		

not doing any glucose monitoring was an extremely serious error.

An interview was conducted on 11/6/20 at 1:29 PM with the thoracic surgeon for Resident #1 (MD #2). MD #2 stated that it was extremely important to have strict blood glucose control after open heart surgery due to the increased risk of infection. MD #2 revealed that while in the hospital the blood glucose levels for Resident #1 were kept under tight control due to the risk of infection. MD #2 stated that omitting the insulin and blood glucose monitoring at the facility could have been fatal for the resident.

An interview was conducted with the facility Administrator on 11/5/20 at 1:40 PM. The Administrator stated that on the evening of 10/5/20 the power of attorney (POA) for Resident #1 came to the facility to pick up the resident's belongings. The Administrator stated that she was notified by the Business Office Manager that the POA had stated Resident #1 was not returning to the facility and was hospitalized due to elevated blood glucose levels. The Administrator stated the next morning on 10/6/20, she and the DON compared the discharge summary from the hospital to the facility orders. After the error in the electronic health record was found, the Administrator stated she began an investigation and immediately started an action plan.

Documentation on the Action Plan stated, A self-imposed action plan by the facility had been completed and implemented on 10/6/2020 with ongoing monitoring to ensure compliance. The action plan was completed on 10/8/20 and the facility alleged compliance as of 10/8/20.

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 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 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 760	Continued From page 7	F 760		

Resident #1 was transferred to the hospital on 10/5/20 from the doctor's office where he had an appointment. Doctor's office informed facility that he was transferred for possible atrial fibrillation.

Identification of other residents:

The Director of Nursing and Unit Managers completed an audit on 10/7/20, for residents that were admitted or readmitted from 9/8/20 through 10/7/20, to validate that orders were transcribed as ordered upon admission. No other residents were identified with transcription errors.

Measures for Systematic change:

The Director of Nursing completed education on 10/7/20 for the Unit Mangers, regarding facility protocol for reconciliation of medications upon admission.

The Director of Nursing and/or Unit Managers completed education on 10/8/20 for current licensed nurses regarding facility protocol for reconciliation of medications upon admission. Newly hired licensed nurses will be educated during new hire orientation.

The process includes upon admission, the licensed nurses will review the discharge summary and will notify the physician or NP to verify orders. The licensed nurse will transcribe the order into the electronic medical record. The unit manager and/or the nursing supervisor will review the orders within 24 hours of admission to validate the physician orders are transcribed accurately into the electronic medical record. When new residents are admitted with a

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 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 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 760	Continued From page 8	F 760		

diagnosis of diabetes and does not have orders for blood sugars to be checked, then blood sugars will be obtained 2x day for 7 days, and the MD/NP will evaluate and determine if blood sugar monitoring should continue.

How corrective action will be monitored:

The DON and/or the unit managers will audit admission orders within 24 hours of admission x 4 weeks then weekly x 2 months, to validate that orders were transcribed accurately into the electronic medical record and residents admitted with diagnosis of diabetes has orders for blood sugar checks.

The DON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance.

The DON will review the plan during the monthly Quality Assurance and Performance Improvement Committee (QUAPI) meeting, and the audits will continue at the discretion of the QUAPI committee. The plan was reviewed in an ad hoc QUAPI meeting held on 10/9/20 and the monthly QUAPI meeting held on 10/21/20.

The facility action plan was verified on 11/6/20 at 2:00 PM. Interviews were conducted with the licensed nursing staff to confirm their knowledge of the protocol for transcription procedures upon admission of a resident as well as their knowledge of the required orders for blood sugar checks for residents admitted with the diagnosis if diabetes. Resident records were reviewed comparing the discharge summary orders to the facility orders upon admission, looking for the systematic changes the facility put in place. The

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 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 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 760	Continued From page 9 facility documentation was reviewed of the initial audit of transcribed records of new admissions from 9/8/20 to 10/9/20, ongoing audits of transcribed records of new admissions, in-service training, and written policy and procedures for reconciliation of medications on admission. Interviews were conducted with members of the QUAPI committee about the action plan.	F 760		