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	345434	A. BUILDING _____ B. WING _____	C 12/14/2021

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CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

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F 000	INITIAL COMMENTS The survey team entered the facility on 12/13/21 to conduct a complaint investigation survey. The survey team was onsite 12/13/21. Additional information was obrtained offsite on 12/14/2021. Therefore, the exit date was 12/14/2021. Event ID# JRY211. 1 of the 11 complaint allegations was substantiated resulting in a deficiency.	F 000		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, staff interviews and the Medical Director interview, the facility failed to consistently evaluate and monitor pain levels for a resident who was receiving as needed (PRN) pain medication for 1 of 1 resident (Resident #1) reviewed for pain management. The findings included: Resident #1 was admitted on 06/20/2021 with diagnoses which included dementia, unspecified fracture of upper end of left humerus, diabetes mellitus and chronic kidney disease. Resident #1 was discharged for a hospital stay on 09/04/2021 and re-admitted to the facility on 09/09/2021. Resident #1 was discharged from the facility on 10/18/2021.	F 697	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 was discharged from the facility on 10/18/2021. Address how the facility will identify other residents having potential to be affected by the same deficient practice: Current facility residents with pain have the potential to be affected by the alleged deficient practice. The Director of Nursing(DON), Assistant	12/30/21

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

Electronically Signed | 12/29/2021

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F 697	Continued From page 1 A review of Resident #1' dated care plan 07/12/2021 revealed she had the potential for pain related to the fracture of her left humerus. Interventions included in part: o Monitor/record/report pain for signs/symptoms of non-verbal pain such as changes in breathing, yelling out, crying and/or changes in mood or behavior. o Monitor and record resident complaints of pain or requests pain for pain treatment. o The resident can call for assistance when she is in pain. She can reposition herself, ask for medication, communicate to the nurse how much pain she is experiencing and communicate what increases or alleviates pain. A review of physician orders for Resident #1 revealed an order was written on 09/09/2021 at 4:45 pm for oxycodone 5mg every 4 hours as needed for pain. Physician order review also revealed an order was written on 09/09/2021 at 11:40 am to assess and document Resident #1's pain every shift and as needed for pain. A review of Resident #1's quarterly Minimum Data Set (MDS) dated 09/20/2021 revealed she had severe cognitive impairment and required extensive assistance for bed mobility, transfer, dressing and toileting. Resident # 1 was administered PRN pain medication and self-reported frequent pain at 5 on a scale of 0-10. Resident #1 received opioid medication on 4 of 7 days. A review of Resident's Medication Administration Record (MAR) for the month of September 2021 revealed since Resident #1's re-admission on 09/09/2021, there were no documented pain assessments for 10 of 22 days and Resident #1	F 697	Director of Nursing(ADON) and Unit Managers(UM) completed an audit on 12/21/2021, of current facility residents with pain and/or receiving pain medication, to validate that residents are being evaluated and monitored for pain, as evidenced by documentation of pain levels and effectiveness of pain medication. Current facility residents have pain evaluation documented on the Medication Administration Record (MAR), every shift and when a PRN medication is given. Address what measures will be put into place or systemic change made to ensure that the deficient practice will not recur: The DON, ADON, and UM completed education on 12/17/2021 for licensed nurses regarding evaluating and monitoring pain for residents, to include documentation of effectiveness of pain medication. Each resident has an order for pain assessment every shift. The licensed nurse will ask or assess the resident for pain and will document on the MAR. When a resident requests a PRN pain medication, the licensed nurse will evaluate/assess the pain level and document before pain medication is given and will document follow up regarding the effectiveness of the pain medication. Indicate how the facility plans to monitor	

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F 697	Continued From page 2 received a PRN pain medication 12 of 22 days. A review of the MAR for the month of October 2021 revealed there were no documented pain assessments for 7 of 18 days and received a PRN pain medication 10 of 18 days. The MAR revealed the following: 09/09/2021-oxycodone 5mg was given at 4:45 pm with a documented pain scale of 7 09/10/2021-oxycodone 5mg was given at 5:35 am with a documented pain scale of 9; oxycodone 5mg was given at 1:10 pm with a reported pain scale 9. 09/11/2021-oxycodone 5mg was given at 1:57 am with a documented pain scale of 8; oxycodone 5mg was given at 2:34 pm with a documented pain scale of 6. 09/12/2021-oxycodone 5mg was given at 5:00 am with a documented pain scale of 9; oxycodone 5mg was given at 5:50 pm with a documented pain scale of 7. 09/13/2021-oxycodone 5mg was given at 5:13 pm with a documented pain scale of 7. 09/14/2021-oxycodone 5mg was given at 8:34 am with a documented pain scale of 3. 09/15/2021-oxycodone 5mg was given at 1:30 pm with a documented pain scale of 5. 09/16/2021-09/20/2021-pain assessments were not documented, and PRN pain medications were not administered. 09/21/2021-oxycodone 5mg was given at 1:40 pm with a documented pain scale of 5. 09/22/2021- pain assessment was not documented, and PRN pain medication was not administered. 09/23/2021-oxycodone 5mg was given at 7:29 am with a documented pain scale of 6. 09/24/2021-oxycodone 5mg was given at 1:17 pm with a documented pain scale of 5. 09/25/2021- pain assessment was not	F 697	its performance to make sure that solutions are sustained: The DON, ADON, and UM will audit pain documentation for 20 residents weekly for 4 weeks then 40 resident monthly for 2 months to validate that licensed nurses are documenting pain assessments every shift and documenting pain assessment before and after administering prn pain medication. THE DON or ADON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON or ADON will review the plan during monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee.	

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documented, and PRN pain medication was not administered.

09/26/2021-oxycodone 5mg was given at 4:58 pm with a documented pain scale of 5.

09/27/2021-09/28/2021-pain assessments were not documented, and PRN pain medications were not administered.

09/29/2021-oxycodone 5mg was given at 9:36 pm with a documented pain scale of 3.

09/30/2021- pain assessment was not documented, and PRN pain medication was not administered.

10/01/2021-oxycodone 5mg was given at 9:00 pm with a documented pain scale of 0.

10/02/2021- oxycodone 5mg was given at 8:30 pm with a documented pain scale of 5.

10/03/2021-oxycodone 5mg was given at 3:56 am with a documented pain scale of 5; oxycodone 5mg was given at 9:08 pm with a documented pain scale of 8.

10/04/2021- oxycodone 5mg was given at 2:04 am with a documented pain scale of 5.

10/05/2021- oxycodone 5mg was given at 4:00 pm with a documented pain scale of 5.

10/06/2021-10/07/2021-pain assessments were not documented, and PRN pain medications were not administered.

10/08/2021- oxycodone 5mg was given at 8:02 am with a documented pain scale of 6.

10/09/2021- oxycodone 5mg was given at 5:27 am with a documented pain scale of 5.

10/10/2021- pain assessment was not documented, and PRN pain medication was not administered.

10/11/2021- oxycodone 5mg was given at 12:03 am with a documented pain scale of 4.

10/12/2021- oxycodone 5mg was given at 8:11 am with a documented pain scale of 6.

10/13/2021- oxycodone 5mg was given at

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10:01 am with a documented pain scale of 4.
10/14/2021-10/18/2021-pain assessments were not documented, and PRN pain medications were not administered.
A phone interview with Resident #1's family member revealed conversations were conducted with various nurses at the facility, (did not remember exact names or dates) regarding Resident #1's pain.

A phone interview with Nurse #4 on 12/14/2021 at 1:24 pm revealed she was working on 10/15/2021 - 10/18/2021 from 7a-7p and was assigned to Resident #1 for the entire shift each of these dates. She stated she was busy, and "working short" at times and should have assessed and documented Resident #1's pain each day as ordered.

A phone interview with Nurse #3 on 12/14/2021 at 1:24 pm revealed she was assigned to Resident #1 on 10/14/2021 from 7a-7p and stated she should have assessed and documented Resident #1's pain each day per physician order. Nurse #3 also stated she was working with Nurse #5 that day and she thought the Nurse #5 documented and assessed Resident #1's pain.

Attempts were made to interview Nurse #5 without success as she no longer works at the facility.

Interview with the Director of Nursing (DON) on 12/14/2021 at 1:31 pm revealed all facility nurses were required to follow physician orders as written, including assessing and documenting pain each shift.

Interview with the facility's Medical Director on

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F 697	Continued From page 5 12/14/2021 at 2:57 pm revealed facility nurses were expected to manage and evaluate resident's pain level and document a pain assessment as ordered by physician. He added pain assessments should be completed each shift for every resident, especially residents receiving PRN pain medications. A phone interview with the Administrator on 12/14/2021 at 3:45 pm revealed facility nurses were required to assess, manage and document resident's pain each day according to physician orders.	F 697		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		12/30/21

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F 880	Continued From page 6 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 7 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews and the Centers for Disease Control and Prevention (CDC) COVID -19 Data Tracker for Durham county level of transmission rate, the facility failed to follow CDC guidance regarding the use of Personal Protective Equipment (PPE) for counties of high and substantial county transmission rates when Nurse #1 failed to wear eye protection when observed assisting 1 of 1 resident (Resident #2) with feeding, when Nurse Aide (NA) #1 and NA #2 failed to wear eye protection when observed transferring 1 of 1 resident (Resident #2) from the chair to the bed using the mechanical lift, and when NA #1 and Nurse #2 were observed assisting 1 of 1 resident (Resident #2) with incontinent care. These practices has the potential to affect all residents who received care from the nursing staff. This failure occurred during a COVID-10 pandemic. Findings included: The CDC guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 09/10/21 indicated healthcare providers working in facilities located in counties with substantial or high community level of COVID-19 transmission should be wearing eye protection (i.e. goggles or a face shield that covers the front and sides on the face) during all patient care encounters.	F 880	F880 The Director of Nursing and/or the ADON provided education on 12/14/2021 for Nurse #1 and NA #1 and NA #2 regarding the use of PPE, to include eye protection during all resident care encounters. No negative effects for Resident #2 were identified. Current facility residents have the potential to be affected by the alleged deficient practice of failure to wear eye protection during resident care encounters. No negative effects was identified. The Director of Nursing, ADON and Unit Managers completed education for current facility staff on 12/15/2021, regarding use of PPE to include eye protection during resident encounters. When facility staff enters into resident care areas, they are to wear the appropriate PPE, to include face masks and eye protection. -The Director of Nursing, ADON and Unit Managers will complete education for all staff by 12/30/2021 regarding the reason and importance for the use of eye protection.	

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F 880	Continued From page 8 The Centers for Disease Control and Prevention(CDC) COVID-19 Data Tracker on 12/13/2021 indicated the level of community transmission for COVID-19 was high in the county where the facility was located. On 12/13/2021 at 9:35 a.m. during the entrance conference, the Administrator stated the county's level of transmission for COVID-19 was high and PPE requirements in the facility was a surgical mask unless a resident was in a quarantine room. On 12/13/2021 at 12:57 p.m., Nurse #1 was observed wearing a surgical mask and no eyewear protection while sitting beside Resident #2 and assisting Resident #2 in feeding her meal tray. Resident #2 was residing in the general population. On 12/13/2021 at 2:04 p.m., NA #1 and NA #2 were observed wearing a surgical mask and no eyewear protection while transferring Resident #2 from the recliner to the bed using a mechanical lift. On 12/13/2021 at 2:12 p.m. in an interview with NA #1, she stated the PPE requirement during resident care for Resident #2 was a surgical mask and gloves were worn as needed. On 12/13/2021 at 2:14 p.m., NA #1 and Nurse #2 were observed wearing a surgical mask and no eyewear protection while providing Resident #2 incontinent care. On 12/13/2021 at 3:45 p.m. in an interview with Nurse #2, she stated she had received PPE training at the facility. She stated wearing a surgical face mask was required when providing	F 880	The Director of Nursing, ADON, and Unit Managers will observe 10 staff members weekly for 4 weeks, the 20 staff members monthly for 2 months to validate that staff members are wearing PPE to include eye protection when in resident care areas and during resident care encounters. The Director of Nursing will review the audits monthly to identify patterns/trends and monitor for compliance and will adjust the plan as necessary to maintain compliance. The Director of Nursing will review the plan during monthly QAPI meeting, and the audits will continue at the discretion of the QAPI committee.	

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care to Resident #2, and protective eyewear was not required when providing care to Resident #2. On 12/13/2021 at 3:55 p.m. in an interview with the Assistant Director of Nursing/Infection Preventionist, she stated for the general population the staff were required to conduct hand hygiene, wear a surgical mask and wear gloves if touching residents during resident care. She stated the Administrator received reports on the county's COVID transmission level and informed the staff on the required PPE for resident care. She stated she was not aware of the CDC guidance requiring the use of eye wear with a substantial or high transmission level in the county, but based on the guidance when providing care to Resident #2, the staff should had been wearing protective eyewear and a surgical face mask.

On 12/13/2021 at 4:10 p.m. in an interview with the Director of Nursing, she stated the Regional Clinical Director provided updates on the county's transmission level and requirements for PPE use. She stated with the county's high level of transmission, the staff were required to wear a surgical mask and use gloves as needed during resident care in the general population, and eyewear protection was required for quarantine and COVID positive residents.

On 12/13/2021 at 4:15 p.m. in an interview with the Administrator, she stated the Regional Clinical Director reported the county's COVID level of transmission every two weeks. She stated on 12/6/2021, the county's transmission rate was reported as high, and the staff were educated on wearing a surgical mask and protective eyewear with resident care. She stated the facility had adequate supply of protective eyewear for the

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staff and based on the CDC guidelines, the staff caring for Resident #2 should had been wearing a surgical mask, protective eyewear and gloves as needed.

On 12/14/2021 at 12:13 p.m. in a phone interview with NA #2, he stated when helping transfer Resident #2 from the chair to the bed on 10/13/2021, he was wearing a surgical mask and no protective eyewear. He stated Resident #2 was not on any isolation precautions and protective ,eyewear was not required. He further stated he had received PPE training at the facility.

On 12/14/2021 at 2:33 p.m. in a phone interview with Nurse #1, she stated on 12/13/2021 when assisting Resident #2 with feeding she was wearing a surgical mask and no protective eyewear. She stated protective eyewear was not required on 10/13/2021 during resident care except when a resident was on isolation precautions. She stated the staff were updated on PPE requirements, and a surgical mask and protective eyewear were required during resident care now.