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 06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

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E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 6/13/2023 through 6/15/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #LU1E11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 6/15/2023. The facility was found to be 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. The following intakes were investigated .NC00200479, NC00200548, NC00200688, NC00200855, NC00200891, NC00200925, NC00201987, NC00202056, NC00202157, NC00202825, NC00203306, NC00203328, NC00203322. 4 of the 47 allegations resulted in deficiency.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff,	F 684	F 684	6/29/23

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

Electronically Signed | 07/05/2023

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F 684	Continued From page 1 physician, and Emergency Medical Services (EMS) staff interviews, the facility failed to assess and seek medical attention for a resident who reported shortness of breath for 1 of 1 resident reviewed for respiratory care (Resident #3). Resident #3 was transferred to the local emergency room and was treated for shortness of breath and significant anemia. The findings included: Resident #3 was admitted to the facility on 2/1/18 with diagnoses that included chronic obstructive pulmonary disease (COPD), shortness of breath, and anxiety. Review of physician's order dated 2/1/18 read: Oxygen at 5 liters (L) via nasal canula continuously every shift for COPD. Review of physician's order dated 3/7/18 read: Obtain vital signs every shift on Wednesday for monitoring. Review of physician's order dated 3/1/19 read: routine resident checks to help maintain resident safety and well-being at least every 2 hours, document exceptions in nurses notes every shift. Review of physician's order dated 12/1/22 read: Albuterol Sulfate Nebulization Solution (2.5MG/3ML) 0.083% 1 vial inhale orally every 3 hours as needed for shortness of breath. Review of Resident #3's Care Plan dated 5/22/22 revealed a focus area of Emphysema/COPD and the goal was for Resident #3 to display optimal breathing patterns daily through next review. Interventions included monitoring for signs and	F 684	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #3 returned from the hospital on 4/9/2023, approximately 12 hours after transfer, with new orders for Prednisone 50mg 1 tablet daily for 4 days. Resident #3 was seen by the facility medical provider on 4/9/2023, upon readmission to the facility, and agreed to continue orders received from the hospital. Resident #3 remains at the facility without any more hospital transfers since readmission on 4/9/2023. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents experiencing a change of condition have the potential to be affected by the alleged deficient practice of failure to assess and seek medical attention, due to nurse staffing assignment sheet did not reflect accurate assignment. The Director of Nursing (DON), Assistant Director of Nursing (ADON) and unit managers (UM) completed an audit on 6/15/23, to identify residents that were experiencing a change of condition and validated that the residents identified were assessed and medical provider notified for treatment. There were no residents identified that were not being assessed	

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F 684	Continued From page 2 symptoms of acute respiratory insufficiency and administering aerosol or bronchodilators as ordered. An additional focus area dated 3/7/23 included a behavior problem as evidenced by overly anxious of medication administration and the goal was to have fewer behavioral episodes weekly by next review. Interventions included administer medications as ordered and to anticipate and meet the resident's needs. Review of the annual Minimum Data Set (MDS) assessment dated 4/12/23 revealed Resident #3 was cognitively intact. The MDS further revealed that Resident #3 was able to make herself understood via clear speech, able understand others and received oxygen therapy during the assessment period. Review of Resident #3's Medication Administration Record (MAR) for April 2023 revealed the following: On 4/8/23 Albuterol was administered at 1:33 AM, 1:00 PM and at 5:18 PM. There were no additional breathing treatments documented on 4/8/23 by facility staff. A routine check was initialed on the MAR for Resident #3 by Nurse #3 on 4/8/23 at 2:34 PM and no additional checks were documented for the remainder of the day. Review of electronic record revealed vital signs documentation on 4/8/23 oxygen saturation level of 99.0% via nasal canula oxygen at 10:54 AM. There were no further vital signs documented on 4/8/23. A review of the rotation schedule for Residents #3's room revealed a total unit census of 64. Nurse #4 and Nursing Assistant #5 were assigned to Resident #3 on 4/8/23 7PM-7AM	F 684	and treated for their change of condition. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The DON provided education to the scheduler and nursing supervisors on 6/15/2023, regarding assignment changes and documentation on assignment sheets to reflect assignments for the nursing staff. If there is a call out, the assignment sheet must reflect the accurate changes so that the nursing staff is aware of their room/cart/hall assignment. The DON, ADON, QA nurse and/or Administrator will review the assignment sheets daily to assure accuracy of assignments. The DON, ADON and QA nurse completed education on 6/29/23, for the licensed nurses, medication aides and certified nursing assistants regarding responding to change of condition. During shift change, the nurses will provide shift report to oncoming nurses identifying residents who have had or at risk for change of condition. The nurses will round on their unit to assess/observe the residents identified with changes or potential for change. If a nursing assistant identifies a change of condition with a resident, they are to immediately notify the licensed nurse. In the event, that a resident presents with a change of condition, that includes, but not limited to mental status change, behavior change, respiratory or cardiac emergency, the licensed nurse will assess the resident	

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F 684	Continued From page 3 shift. Nurse #6 was assigned to the residents on the front end of the hall and Nurse #5 was assigned to the back end of the hall but was noted as a call out. There were no medication aide staff members noted on this schedule. A review of the facility staff punch detail noted Medication Aide #1 to have worked on 4/8/23 from 7:57 AM to 8:40 PM. Nurse #4 worked on 4/8/23 from 7:55PM to 7:31AM and Nurse #3 worked on 4/8/23 from 7:00AM to 8:30PM. Nurse #3 was interviewed on 6/14/23 at 11:55 AM. He revealed that he did not recall working on 4/8/23 but indicated that he was assigned to Resident #3 on a regular basis, and she was known to use her call light and to verbally notify staff if she has difficulty breathing. Review of Nurse #4 progress note dated 4/8/23 read in part; Resident #3 called EMS due to shortness of breath. EMS responded at 9:30 PM, resident was resistive to hospitalization initially but was sent to the hospital for evaluation and treatment at 10:55 PM. Nurse #4 was interviewed via phone on 6/14/23 at 2:08 PM. Nurse #4 recalled working on the evening of 4/8/23 but did not recall the specifics of receiving report from Nurse #3. She revealed Resident #3 was sent out to the hospital during her shift and she was unaware that she was assigned to the resident until EMS entered the building and approached her about Resident #3's health concerns. Once EMS made her aware of the situation, she walked down to the room to talk to Resident #3 and assist EMS with the transfer to the hospital. Resident #3 received treatment from EMS for her shortness of breath and then	F 684	and initiate appropriate interventions. The licensed nurse will notify the medical provider for orders and implement orders when received. Nursing staff that were not available for education on 6/29/23, will be educated upon return to work. Newly hired nursing staff will receive education during orientation. The clinical team which includes but not limited to DON, ADON, Unit managers, MDS nurses, and Social worker will continue to review progress notes and incident reports during morning clinical meeting 5 days a week to identify residents with change of condition or incidents, to assure assessments, medical provider notification and follow up occurred. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON, ADON, QA nurse and/or the administrator will review assignment sheets daily 5x week for 4 weeks, then 3x week for 2 months, to validate that assignment sheets reflect accurate staffing and staff have written assignment of their rooms/carts/hall assignments. The QA nurse and/or Administrator will review IDT clinical meeting notes daily 5 x week x 4 weeks then 3 x week for 2 months, to validate that the team has reviewed progress notes and/or incident reports and assessment and follow up occurred. The DON and/or QA nurse will review the audits monthly to identify patterns and	

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F 684	Continued From page 4 sent to the hospital. An interview was conducted with Nursing Assistant # 5 on 6/14/23 9:58 AM. She revealed that that she didn't recall the evening of 4/8/23 or the events leading up to Resident #3 being sent out to the hospital but was assigned to Resident #3. A telephone interview was conducted on 6/15/23 at 10:54 AM with Nurse # 5 who revealed she was not aware of this incident as she had to call out the evening of 4/8/23 and did not come into the facility on 4/8/23. An attempt was made to interview Nurse #6 (agency) who was assigned to Resident #3's hall on 4/8/23 but on another section, but facility was not able to produce a contact number for the interview. A telephone interview was conducted with Medication Aide #1 on 6/15/23 at 2:43 PM and she revealed that she was not assigned to Resident #3 and did not administer medications to her on the evening of 4/8/23. She does not recall any staff member making her aware of Resident #3's concern of shortness of breath. An interview was conducted with Resident #3 on 6/13/23 at 1:41 PM. She revealed that she contacted EMS via 911 call on 4/8/23 due to having a lot of trouble breathing most of that evening and had requested her next dose of available medication for shortness of breath to the evening shift (7 PM-7 AM) nursing assistant but she told her it was too early for her medication. Resident #3 further revealed that she recalled telling her nursing assistant several times	F 684	trends and will adjust the plan as necessary to maintain compliance. The DON and/or QA nurse will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; 6/29/2023	

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to let the nurse know again that she was still having trouble breathing and wanted her breathing treatment but was told that it was not time yet for her medicine. She waited about an hour and when the nurse still had not come to her room, she felt she had to call 911 to get help. EMS staff came in and gave her several treatments and they did help in part and felt that she did not need to go to the hospital. The EMS staff member and the doctor (via telephone) talked to her about their concerns and recommendation to go to hospital. She further revealed that when she went to the hospital, she was told that she was anemic and had to get a blood transfusion and was started on prednisone.

Review of EMS incident report dated 4/9/23 revealed in part: Resident #3 contacted EMS by telephone on 4/8/23 at 9:33 PM and reported that she could not breath and had not had her medicine. EMS arrived at the facility at 9:43 PM and received a brief report by a staff member who indicated Resident # 3 had been asking for her medications due to shortness of breath, but it was not time yet for her to receive medication. At 9:44 PM, EMS staff found Resident #3 in a sitting position in her bed, alert and oriented to person, place, time, and situation. EMS staff checked oxygen saturation level at 9:44 PM and was at 97 % however Resident #3 was observed to be tachypneic (abnormal rapid breathing), pale, and having heavy chest wall movement. Resident #3 received the following medications that were administered by EMS staff between 9:46 PM through 10:37 PM.

" Oxygen at 8 lpm (liters per minute) via nasal cannula

" Albuterol 5mg (milligram) via nebulizer (used to treat respiratory conditions)

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" Ipratropium 0.5 mg via nebulizer (used to treat respiratory conditions)
" 20 gauge Antecubital (arm in front of the elbow) Right Saline lock via IV.
" Albuterol 2.5 mg via nebulizer (used to treat respiratory conditions)
" Ipratropium 0.5mg via nebulizer (used to treat respiratory conditions)
" Methylprednisolone 125 mg intramuscular (used to treat for inflammation)
" Albuterol 5mg via nebulizer (used to treat for respiratory conditions)
" Ipratropium .5mg via nebulizer (used to treat for respiratory conditions)
" Consult with EMS physician and patient regarding high-risk refusal and counselling with patient regarding need for hospitalization.

On 6/15/23 at 2:56 PM a telephone interview was conducted with the lead EMS crew member who treated Resident #3 on the night of 4/8/23. She revealed that she and two other EMS crew members arrived at the facility on 4/8/23 at approximately 9:40 PM. She observed Resident #3 sitting in bed with oxygen at 5 L via nasal cannula, and breathed very quickly and used her whole upper body to breath. She checked her oxygen saturation level, and it was at 97% but she was visibly breathing hard and could not get a full breath. Resident #3 was described as feeling clammy and sweaty to touch. The EMS crew member gave Resident #3 multiple breathing treatments, and her oxygen saturation level would go up but then fall back down and could not keep her stable without intervention. The lead EMS Staff member spoke with a facility staff member who was at the medication cart and asked why Resident #3 had not yet been assessed by a nurse or received medication to

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address her complaints of shortness of breath. The staff member responded that they were short of staff tonight due to a nurse call out and nobody has gotten down there yet and that she had not received medication because it was not time yet. She asked when the staff member thought someone would be able to get to Resident #3's room and was told that she did not know how long it would be until a nurse could get down to her room. The EMS staff member returned to Resident #3 to continue to treat her shortness of breath and to discuss hospital transfer. Resident #3 indicated at first that she did not want to go to the hospital but then after consulting with an EMS physician via telephone she decided to proceed with the hospital transfer, and they exited the facility around 10:55 PM that night.

Review of the emergency department provider note from the local hospital dated 4/9/23 read in part; date of service 4/8/23 at 11:33 PM, diagnoses: anemia, acute dyspnea (breathing discomfort), shortness of breath and COPD exacerbation (worsening of respiratory symptoms associated with COPD). The provider notes further read in part: Resident #3's labs, were unremarkable with exception of significant anemia (not enough red blood cells or hemoglobin to carry oxygen throughout the body). A point-of-care basic metabolic panel (BMP) was performed to confirm. The BMP showed a hemoglobin level of 5.1 grams per deciliter (gm/dl) (a hemoglobin's normal range for a female is 12.3gm/dl and 15.3gm/dl) which resulted in Resident #3 requiring a blood transfusion of 2 units of packed red blood cells. She discharged back to the facility on 4/9/23 with a prescription for prednisone for the next 4 days.

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A telephone interview was conducted with Unit Manager/Nurse on call #1 on 06/15/23 at 10:54 AM who stated that she was on call the evening of 4/8/23 and was not notified by the facility of any staff call outs on 4/8/23 or any issues regarding Resident #3. If she were made aware of a call out it was her job to find a replacement or reorganize the assignment to ensure all residents have adequate staff available to them.

An interview was conducted with the Director of Nursing (DON) on 6/15/23 at 3:40 PM and she revealed that if a resident was experiencing shortness of breath they should be assessed and provided medications as ordered by the physician.

The Physician was interviewed at the facility on 6/14/23 at 1:20 PM. He explained that he was Resident #3' s physician and that it was his expectation that nursing staff assess any resident who has expressed or showed signs of shortness of breath and medicate according to the current orders.