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|---|---|---|---|
| | 345434 | A. BUILDING ______ B. WING ______ | C 02/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted from 02/03/25 through 02/07/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # FNMO11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey were conducted from 02/03/25 through 02/07/25. The following intakes were investigated: NC00218629, NC00219239, NC00219593, NC00219767, NC00219845, NC00220424, NC00220414, NC00221604, NC00221788, NC00221719, NC00222248, NC00223250, NC00223452, NC00223889, NC00223937, NC00224267, and NC00224671.<br><br>14 of the 61 complaint allegations resulted in deficiency.<br><br>Immediate Jeopardy was identified at:<br>CFR 483.35 at tag F726 at a scope and severity (J)<br>CFR 483.80 at tag F880 at a scope and severity (J)<br><br>Immediate jeopardy began on 2/4/25 and was removed on 2/6/25. | F 000 | | |
| F 565 SS=D | Resident/Family Group and Response<br>CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)<br><br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, | F 565 | | 3/4/25 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 02/28/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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|---|---|---|---|---|
| F 565 | Continued From page 1<br>to make residents and family members aware of upcoming meetings in a timely manner.<br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.<br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.<br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.<br>(A) The facility must be able to demonstrate their response and rationale for such response.<br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.<br><br>§483.10(f)(6) The resident has a right to participate in family groups.<br><br>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interviews and Resident Council Interview, the facility failed to resolve grievances that were reported during Resident Council meetings for 3 of 3 consecutive months (November 2024, December 2024 and January 2025).<br><br>Findings included: | F 565 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice<br>" The Social Services Director reviewed all grievances reported during the November 2024, December 2024, and January 2025 Resident Council meetings, | |

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|---|---|---|---|---|

F 565

Continued From page 2

The Resident Council minutes were reviewed for the past 12 months and it was observed the most recent 3 months (November 2024, December 2024 and January 2025) did not include resolutions to the concerns expressed.
- November 13, 2024, Resident Council Meeting minutes noted concerns about receiving their medications late on night shift.
- December 27, 2024, Resident Council Meeting minutes noted concerns night shift was not answering call lights.
- January 24, 2025, Resident Council Meeting minutes noted concerns regarding nurse and nurse aide care on night shift.

During the Resident Council Interview on 2/05/25 at 2:30 PM, residents present stated they had ongoing concerns regarding the night shift staff and did not think their concerns had been resolved related to receiving medications, call lights and nurse and nurse aide care.

An interview with the Activities Director was conducted on 2/07/25 at 12:01 PM. She stated when there was a concern, she would write it up on a grievance notice and would give it to the responsible party for follow up. She explained she thought she had written up grievances but would have to check.

An interview with the Administrator was conducted on 2/07/25 at 3:55 PM. The Administrator stated he had attended the January Resident Council Meeting and had asked if anything was unresolved, and they said they had no concerns. After checking for grievances from the Resident Council from November, December and January, none were discovered. He stated he

F 565

ensuring each grievance received a thorough investigation and response. The Social Services Director documented the facility's response and rationale for each grievance and communicated these responses to the Resident Council.
" Completion Date: 02/24/2025

Address how the facility will identify other residents having the potential to be affected by the same deficient practice
" The Social Services Director/designee conducted a comprehensive review of all Resident Council meeting minutes from the past six (6) months to identify any additional unresolved grievances or recommendations that may require follow-up, investigation, and response. This review included verification that each grievance received a documented facility response and rationale.
" Completion Date: 02/24/2025

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
" The Social Services Director/designee will attend all monthly Resident Council meetings as allowed approved personnel by the resident council to document grievances and recommendations in real-time. These items will be reviewed during daily interdisciplinary clinical meetings to ensure prompt investigation and resolution. The Administrator/designee will review all Resident Council grievances weekly to ensure appropriate and timely responses

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|---|---|---|---|
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| 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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|---|---|---|---|---|
| F 565 | Continued From page 3<br>would expect all grievances to be documented and addressed. | F 565 | are documented and communicated back to the Resident Council.<br>" The Administrator/designee will provide education to all department managers regarding the requirement to promptly address and resolve Resident Council grievances, including the need to document the facility's response and rationale for each grievance. Staff will not be allowed to work until they have received the required education, and documentation of attendance will be maintained in employee training records.<br>" Completion Date: 03/4/2025<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained<br>" The Administrator/designee will conduct monthly audits of all Resident Council meeting minutes and grievance documentation for six (6) consecutive weeks, then monthly for three (3) months to ensure all grievances receive prompt investigation, documented responses with rationale, and communication back to the Resident Council. Any identified deficiencies will be corrected immediately, and additional education will be provided to the involved staff.<br>" Results of these audits will be reviewed and analyzed by the QAPI/QA Committee for trends and additional corrective action.<br>" This plan of correction will be monitored at the monthly QAPI/QA meeting until such time consistent substantial compliance has been met.<br>" Completion Date: 03/04/2025 and | |

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|---|---|---|---|---|
| F 565 | Continued From page 4 | F 565 | ongoing | |
| F 600 SS=E | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, and resident, staff and Nurse Practitioner interviews, the facility failed to protect the rights of residents from resident to resident abuse for 4 of 5 residents reviewed for abuse. (1) On 8/2/2024, two residents, Resident #52 and Resident #104, who had a previous history of a resident-to-resident altercation on 6/9/2024, were involved in a resident to resident altercation in the smoking area. Nursing staff responded to a loud noise from the smoking area and observed Resident #52, who had a history of aggressive behavior, lying on the concrete floor of the smoking area. Resident #104 was observed sitting in his wheelchair. Resident #52 and Resident #104 were observed swinging their arms and hitting each other. The nursing staff immediately separated Resident #52 and #104. | F 600 | Past noncompliance: no plan of correction required. | |

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|---|---|---|---|
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|---|---|---|---|---|
| F 600 | Continued From page 5 | F 600 | | |

(2) On 10/20/2024, Resident #47 struck Resident #17 in the face when Resident #17 did not move for Resident #47 when Resident #47 entered the smoking area.

Findings included:

1. Resident #52 was admitted to the facility on 10/22/2014 with diagnoses including traumatic brain injury and a stroke.

Resident #52's care plan included a focus revised on 3/27/2024 for verbal and physical aggressive behaviors towards the staff and other residents. Altercations with another resident was recorded on 6/9/2024 and 8/2/2024. The goal for Resident #52's behaviors was to have fewer episodes of verbal aggression and demonstrate effective coping skills. Interventions included increased monitoring that included every 15 minute checks to one-to-one staffing and psychiatric evaluations for behaviors.

Resident #52's smoking assessment dated 5/23/2024 indicated Resident #52 was an unsupervised smoker (the ability for a resident to go to the designated smoking area without the supervision of a staff member)

The quarterly Minimum Data Set (MDS) assessment dated 6/15/2024 indicated Resident #52 was cognitively intact and physical behaviors had been directed toward others for 1-3 days. The MDS also indicated Resident #52 could independently operate his wheelchair.

Resident #104 was admitted to the facility on 3/22/2024 with diagnoses including diabetes mellitus and end stage renal disease.

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|---|---|---|---|---|
| F 600 | Continued From page 6 | F 600 | | |

Resident #104's smoking assessment dated 5/20/2024 indicated Resident #104 was a unsupervised smoker.

Resident #104's care plan dated 6/10/2024 recorded Resident #104 exhibited behaviors evidence by a resident to resident altercation in which Resident #104 struck another resident. Interventions included immediate separation from the other resident, one-to-one monitoring, caregivers providing opportunity for positive interactions and attention by stopping by and talking with Resident #104 and explaining and reinforcing why Resident #104's behavior was inappropriate and unacceptable. The care plan was revised on 7/2/2024 to include every 15 minute checks and on 8/3/2024 for one-to-one monitoring.

The quarterly Minimum Data Set (MDS) assessment dated 7/8/2024 indicated Resident #104 was cognitively intact and independently operated his wheelchair. Resident #104 was not coded for any behaviors during the 7-day look back period of the MDS assessments.

An incident report for Resident #52 dated 8/2/2024 at 7:30 pm completed by the Director of Nursing (DON) reported Resident #52 was involved in a resident -to- resident altercation with Resident #104 that initially started as a verbal confrontation. When Resident #104 rolled past Resident #52, a physical altercation occurred and Resident #52 was pushed to the floor. Resident #52 and Resident #104 were immediately separated and Resident #52 was assessed by a nurse. Resident #52 refused to make a statement. Immediate action included immediate

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|---|---|---|---|---|
| F 600 | | F 600 | | |

Continued From page 7
separation of Resident #104 and Resident #52 and placing Resident #52 on increased monitoring (every 15 minute checks), an assessment of Resident #52, a psychosocial and behavioral assessment and a skin assessment that reported an abrasion to Resident #52's back right shoulder and bruise to face, and back right shoulder. The Physician and Resident #52's Representative was notified. The incident report recorded no witness were found to the resident-to- resident altercation.

Nursing documentation recorded the following:
- 8/2/2024 at 10:47 pm by Nurse #26: Resident #52's representative was at bedside and Resident #52 was medicated for complaints of right neck pain, right inner thigh pain after the resident- to-resident altercation with Resident #104. Nursing documentation further recorded Resident #52 refused to go to the hospital for further evaluation.
- 8/3/2024 at 10:20 am by the DON: Resident #52 sustained a fall to the floor as a result of physical contact with Resident #104. Resident #52 was assessed for injuries that included bruise and abrasion to the back of the right shoulder, right upper back and bruise to face and cheek. Resident #52 was placed on increasing monitoring (15 minute checks) at time of incident and Resident #52 representative notified.
- 8/3/2024 at 12:46 pm by the DON: Resident #52 placed on one-to-one supervision due to incident with another unidentified resident and Resident #52 was agitated about having one-to-one supervision.
- 8/3/2024 at 1:28 pm by Nurse #27: Psychiatry telehealth evaluation completed and Resident #52 was ordered haloperidol (an antipsychotic medication used to treat agitation and acute psychosis to improve thinking, mood and

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|---|---|---|---|
| | 345434 | A. BUILDING ______ B. WING ______ | C 02/07/2025 |

| 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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|---|---|---|---|---|
| F 600 | | F 600 | | |

Continued From page 8
behavior) 1 milligram (mg) twice a day for agitation.

Physician orders dated 8/3/2024 included an one-time order for haloperidol 1 mg for explosive personality disorder and an order for haloperidol twice a day for explosive personality disorder. There was an order to discontinue haloperidol on 8/5/2024.

Physician progress notes dated 8/5/2024 recorded Resident #52 continued to have occasional aggressive behaviors and altercations with other residents. Resident #52 was on one-to-one supervision due to a resident-to-resident altercation where Resident #52 and Resident #104 were hitting each other. Resident #52 sustained bruise to right shoulder, back and left cheek and denied any discomfort. The physician recorded Resident #52's representative voiced concerns with Resident #52 sleepiness after psychiatry physician started Resident #52 on Haloperidol 1 milligram twice a day and was sent to the hospital per Resident #52's representative request for evaluation of ongoing progressive behaviors and fall after the one-to-one altercation on 8/2/2024.

Follow up physician progress notes dated 8/6/2024 post the hospital visit recorded radiology tests were negative for injury. Resident #52 complained of back pain and was started on Oxycodone 5 milligrams for pain for 5 days.

Psychiatric physician notes dated 8/14/2024 recorded anxiety as possible cause for Resident #52's impulsive behavior and agitation. There was no changes in Resident #52's medications and monitoring Resident #52's behaviors, using

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|---|---|---|---|
| | 345434 | A. BUILDING ______ B. WING ______ | C 02/07/2025 |

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| CARVER LIVING CENTER | 303 EAST CARVER STREET DURHAM, NC 27704 |

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|---|---|---|---|---|
| F 600 | Continued From page 9 | F 600 | | |

different smoking areas and avoiding triggers that caused altercations with others was the plan. The psychiatric physician note further stated one-to-one supervision was at the discretion of the facility.

An incident report for Resident #104 dated 8/2/2024 at 7:00 pm completed by Nurse #23 recorded Resident #104 stated Resident #52 came up to him and started yelling at him and hitting him on his shoulder and legs. Resident #104 stated he hit Resident #52 back to defend himself. He stated an nurse aide came and assisted with separating the two residents. Immediate actions included one-to-one supervision until completion of the investigation, notification of physician, an assessment of Resident #104, skin assessment, psychological assessment and behavioral assessment for Resident #104. Resident #104 was observed with no injuries. The incident report indicated Resident #104 was his own representative.

Physician progress notes dated 8/6/2024 recorded Resident #104 was on one-to-one supervision and received no injury from the resident-to-resident altercation on 8/2/2024.

There was no physician order for a psychiatry evaluation in Resident #104's electronic medical record.

In a written statement from Resident #104 dated 8/3/2024, Nurse #23 recorded Resident #104 stated Resident #52 went charging at him and Resident #104 went on Resident #52, hitting Resident #52 really hard and knocking Resident #52 out of his wheelchair. Resident #104 stated Resident #52 hit him in the face, beat Resident

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|---|---|---|---|---|
| F 600 | Continued From page 10 #104 on his leg and called Resident #104 bitches. | F 600 | | |

The Initial allegation report dated 8/3/2024 and signed by the former Director of Nursing was submitted to the state agency. The initial allegation report recorded Resident #52 an Resident #104 were noted with a verbal altercation that escalated to Resident #52 and Resident #104 physically struck each other when Resident #104 rolled past Resident #52 in a wheelchair. Resident #52 and Resident #104 were immediately separated and placed on one-to-one supervision to ensure the safety of others and an investigation was initiated. The initial allegation report recorded follow-up assessments on Resident #52 reported minor injuries that required no treatment and reported Resident #104 with no injuries. An psychosocial assessment completed on both Resident #52 and Resident #104 reveal no mental anguish. The initial allegation report recorded the local police department was notified on 8/3/2024 at 10:15 am.

A review of witness statements from residents dated 8/2/2024 and 8/3/2024 reported Resident #52 and Resident #104 were in the smoking area when Resident #52 and Resident #104 started arguing and hitting each other. Resident #52 stood up from his wheelchair and fell to the ground. Nursing staff came and split Resident #52 and Residennt #104 up.

A review of witness statements from nursing staff dated 8/3/2024 when interviewed by Nurse #23 stated the resident-to-resident altercation had started prior to the nursing staff arriving on the scene, and Resident #52, who was lying on the ground and Resident #104, who was in his wheelchair, were swinging their arms hitting each

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|---|---|---|---|
| | 345434 | A. BUILDING ______<br>B. WING ______ | C<br>02/07/2025 |

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

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|---|---|---|---|---|
| F 600 | Continued From page 11<br>other.<br><br>The 5-day investigation report dated 8/9/2024 and signed by the former Director of Nursing was submitted to the state agency for resident abuse and reported per witness statements obtained Resident #52 came to the smoking area where Resident #104 was at and verbally began to argue with Resident #104. Resident #52 struck Resident #104 and after being struck, Resident #104 struck Resident #52 back and Resident #52 stood up from his wheelchair. Resident #52 and Resident #104 were separated, placed on one-to-one supervision and assessed by the nursing staff. Resident interviews were completed with interviewable residents and skin assessments completed on non-interviewable residents with no new findings. Staff interviews completed to identify any other potential for resident -to- resident altercation or increased agitation with no new findings. Resien #52 and Resident #104 remained on one-to-one supervision. The 5-day investigation report also recorded the Department of Social Service was notified on 8/5/2024 with no on-site visit conducted.<br><br>On 2/3/2025 at 2:56 pm in an interview with Resident #52, he answered "yes" to having been in a resident-to-resident altercation and denied any injury from the altercation. He declined to talk about the resident-to-resident altercation.<br><br>On 2/4/2025 at 6:38 am in an interview with Resident #104, he explained on 8/2/2025 when he was in the smoking area, Resident #52 put his hands like a fist to his chest when he went to go around Resident #52. He stated he struck Resident #52 back in the face and they continued | F 600 | | |

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| F 600 | Continued From page 12<br>to hit each other until staff arrived and separated Resident #52 and Resident #104. He said he was placed on one-to-one supervision for a while and stated there had been no further resident-to-resident altercations with Resident #104 or any other residents.<br><br>On 2/4/2025 at 10:32 am in a follow up interview with Resident #52, when asked specifically about the resident-to-resident altercation in August 2024 with Resident #104, Resident #52 declined to discuss the altercation. He stated he felt safe in the facility and was not afraid of Resident #104 or any other residents. He stated he was placed on 1:1 supervision that was recently discontinued.<br><br>On 2/5/2025 at 2:57 pm in an interview with Nurse Aide (NA) #11, she remembered Resident #52's and Resident #104's resident-to-resident altercation on 8/2/2024 occurring in the smoking area. She stated she was assisting another resident to the smoking area and observed Resident #52 on the ground and another staff member was moving Resident #104's wheelchair back away from Resident #52 to separate the residents. She stated Resident #104 went to the smoking area to smoke daily, and Resident #52 seldom went to the smoking area since the weather turned cold outside. NA #11 was unaware of any further resident-to-resident altercations between Resident #52 and Resident #104 since 8/2/2024.<br><br>On 2/5/2024 at 3:10 pm in an interview with NA #10, she stated she was assigned one-to-one supervision to Resident #52 after the resident-to-resident altercation with Resident #104. She stated Resident #52 informed her that Resident #52 and Resident #104 were arguing, | F 600 | | |

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|---|---|---|---|---|
| F 600 | Continued From page 13<br>cursing and Resident #104 tried to run over him with Resident's wheelchair. She stated she was not present during the resident-to-resident altercation.<br><br>On 2/5/2024 at 3:20 pm in an interview with the Transportation Coordinator, she stated on 8/2/2024 while walking in the hallway, she heard loud cursing from outside in the smoking area. She responded to the area and observed Resident #104 in his wheelchair on top of Resident #52 who was on the concrete ground. She stated she called for help and other nursing staff responded to help separate Resident #52 and Resident #104. She said she was not aware of any other resident-to-resident altercations since August 2024 between Resident #52 and Resident #104, and she had noticed Resident #52 and Resident #104 stayed away from each other in the facility. She explained the nursing staff also tried to ensure Resident #52 and Resident #104 were not in the same area at the same time to prevention any other resident-to-resident altercation.<br><br>On 2/6/2025 at 7:08 am in an interview with Nurse #25 she stated Resident #52 and Resident #104 had a history of verbal and physical altercations and recalled Resident #52 and Resident #104 on one-to-one supervision after a resident-to-resident alteration. She explained Resident #52 would argue with other residents if he did not like them and was sexually inappropriate with nursing staff. She said the nursing staff tried to keep Resident #52 away from other residents to keep a peacefu environment. She stated Resident #52 usually stayed in his room and went to the smoking area during the night. Nurse #25 was unable to recall | F 600 | | |

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|---|---|---|---|
| | 345434 | A. BUILDING ______ B. WING ______ | C 02/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 600 | Continued From page 14 | F 600 | | |

any further resident-to-resident incidents involving Resident #52 since August 2024 and stated the Director of Nursing determined when one-to-one supervision was discontinued for residents. Nurse #25 stated Resident #104 usually didn't argue with other residents unless he was provoked, and Resident #104 spent a lot of time outside the facility. She explained Resident #52 and Resident #104 were to smoke in separate smoking areas or at different times to prevention further resident-to-resident- altercation.

On 2/7/2025 at 7:53 am in an interview with Smoking Aide #3, she stated after the resident-to-resident altercation between Resident #52 and Resident #104 in August 204, the Administrator had informed the smoking aides (smoking aide: a person who supervised the resident smoking area) that Resident #52 and Resident #104 were not to be together in the smoking area. She explained Resident #104 came out to smoke all the time with no verbal or physical aggressive behaviors observed toward other residents or staff. She explained Resident #52 had a sitter for a long time period and would go to the employee smoking area to smoke until it became too cold to come outside to smoke.

Attempts to interview Nurse #23, who no longer worked at the facility, were unsuccessful.

On 2/7/2025 at 10:18 am in a phone interview with Nurse Practitioner #2, she explained she was no longer working with the facility and did not have access to residents' medical records. She recalled Resident #52 and Resident #104 having two resident-to-resident altercations (6/24/2024 and 8/2/2024). She explained Resident #104 was displaying a new behavior and no medications

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 600 | Continued From page 15<br>were ordered to manage his behavior and could not recall if a psychiatry evaluation was ordered. She stated Resident #52 had a history of aggressive behaviors toward others and was followed by psychiatry for depression. She stated Haloperidol was ordered in an attempt to manage Resident #52's aggressive behaviors after the resident-to-resident altercation on 8/2/2024 and was discontinued at the request of Resident #52's Representative due to a concern causing Resident #52 to be drowsy. She explained Resident #52 and Resident #104 were placed on one-to-one supervision, and the Director of Nursing determined when one-to-one supervision was discontinued based on when no aggressive behaviors were observed.<br><br>On 2/7/2025 at 6:53 pm in a phone interview with the former Director of Nursing (DON), she recalled Resident #52 and Resident #104 engaging in a couple of resident-to-resident verbal and physical altercations while working at the facility. She recalled completing the initial and investigation report for the state agency and stated Resident #52 would not provide the facility with a statement. She stated the goal of the facility was to keep Resident #52 and Resident #104 safe. She explained Resident #52 and Resident #104 were placed on one-to-one supervision, and their behaviors were monitored until behaviors stabilized. She stated staff ensured Resident #52 and Resident #104 were smoking in different smoking areas even with one-to-one supervision. She explained Resident #52 had a psychiatric evaluation with a medication change ordered, and she was unable to recall if Resident #104 was ordered a psychiatric evaluation. She stated the facility initiated and completed a plan of correction after | F 600 | | |

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|---|---|---|---|
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|---|---|
| CARVER LIVING CENTER | 303 EAST CARVER STREET DURHAM, NC 27704 |

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| F 600 | Continued From page 16<br>the resident-to-resident altercation and was unable to recall any further resident-to resident altercations between Resident #52 and Resident #104 after 8/2/2024.<br><br>On 2/7/2024 at 5:24 pm in an interview with the Director of Nursing, who started in October 2024, she stated Resident #52 had been choosing not to leave his room and when he went to smoke, there was one-to-one supervision with Resident #52 in the smoking area. She explained Resident #104 had not been on one-to-one supervision since she started in October 2024. She stated the nursing staff continued to monitor Resident #52 and Resident #104 for behaviors and were to report any behaviors exhibited by the residents to Administration immediately. She stated there had been no further resident-to-resident altercations with Resident #52 and Resident #104 or with other residents reported since October 2024,<br><br>On 2/7/2024 at 4:53 pm in an interview with the current Administrator, he stated he started at the facility three weeks ago. He stated Resident #52's one-to-one supervision had been reviewed with the Director of Nursing, and it was determined on 1/31/2025 due to Resident #52 not exhibiting any inappropriate behaviors to discontinue the one-to-one supervision. He stated Resident #52 was on every 15 minute checks as long as there were no inappropriate behaviors observed toward others.<br><br>On 2/7/2024 at 5:10 pm in an interview with the current Administrator, he explained Resident #52's one-to-one supervision for the resident-to-resident altercation was changed to every 15 minute checks on 8/5/2024 and was on one-to-one supervision until 1/31/2025 for | F 600 | | |

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|---|---|---|---|
| | 345434 | A. BUILDING ______ B. WING ______ | C 02/07/2025 |

| 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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|---|---|---|---|---|
| F 600 | Continued From page 17 | F 600 | | |

inappropriate sexual behaviors toward the staff and not argumentative behaviors with other residents and staff. He stated Resident #104's one-to-one supervision was discontinued on 9/23/2024.

2. Resident #47 was admitted to the facility on 6/3/22 with diagnoses of hypertension, diabetes, cerebral vascular accident, and left-hand contracture/hemiparesis.

A focus area on the care plan dated 9/14/24 revealed Resident #47 had a behavior problem as evidenced by episodes of verbal/physical aggression towards other residents within the facility. The goal included Resident #47 would have no evidence of behavior problems. The interventions included on 10/20/24 one-to-one supervision, administer medications as ordered. Monitor/document for side effects and effectiveness. Assist him to smoke in separate supervised smoking areas. Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention and remove from the situation and take him to an alternate location as needed. Monitor behavior episodes and attempt to determine underlying causes. Consider location, time of day, person(s) involved, and situations. Document behavior and potential causes.

Review of quarterly Minimum Data Set (MDS) assessment dated 12/15/24 indicated Resident #47 was severely cognitively impaired with cognitive communication deficit and behaviors.

Resident #17 was admitted to the facility on 12/24/20 with the diagnoses of metabolic

| 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 02/07/2025 |

| 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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|---|---|---|---|---|
| F 600 | Continued From page 18<br>encephalopathy, dementia, cerebral vascular accident, epilepsy, chronic obstructive pulmonary disease, schizophrenia, and lung cancer and cognitive communication deficit.<br><br>The quarterly Minimum Data Set (MDS) dated 11/30/24, indicated Resident #17 was severely cognitively impaired and no behaviors.<br><br>The initial allegation report dated 10/20/24 the facility became aware of the resident-to-resident altercation on 10/20/24 at 10:20AM while the two residents were outside on the patio. The alleged victim was Resident #17 and Resident #47 was the perpetrator. Resident #47 was observed by staff hitting Resident #17 in the face. Nurse Aide #6 and the Housekeeping Supervisor were present in the area. The Nurse Aide #6 immediately was able to remove Resident #17 from Resident #47's personal space. Nurse #19 notified the nurse practitioner and responsible parties for both residents. Nurse #19 assessed both residents and Resident #17 had a small swollen red around below the left eye. Resident #47 was placed on 1:1 supervision and x-rays were ordered for Resident #17.<br><br>A review of the 5-day investigation report dated 10/24/24 revealed the x-ray results for Resident #17 was negative and both residents were evaluated by psychiatric services and Resident #47 was placed on 1:1 supervision and medications were adjusted. Both residents were provided with separate smoking areas. Skin assessments were done on other residents with no new findings. Other residents were interviewed about abuse and safety awareness and there were no new findings. Staff interviews and training on abuse and behavior management | F 600 | | |

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|---|---|---|---|
| | 345434 | A. BUILDING _____ B. WING _____ | C 02/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 600 | Continued From page 19<br>were completed.<br><br>An interview was conducted on 2/3/25 at 11:30 AM with Resident #47 who stated he does not recall having an altercation with anyone.<br><br>An interview was conducted on 2/5/24 at 2:24 PM, with the Housekeeping Supervisor who stated she was passing by the common area for the smokers when she heard Resident #47 telling Resident #17 to move out of the way. Resident #47 did not like others to be in his personal space. Resident #17 moved very slowly and as he was trying to move out of the way as the wheelchairs bumped into one another and Resident #47 hit him in the face. Resident #17 did not retaliate back to Resident #47. She further stated Nurse Aide #6 who was in the area immediately separated the two residents and the nurse supervisor was notified of the incident.<br><br>An interview was conducted on 2/6/25 at 4:55 PM, with Nurse Aide #6 who stated she was assisting another resident with the door near the smoking area when she observed Resident #47 hitting and punching Resident #17 in the face. She stated she immediately separated the two residents; she stated the only time the two residents interacted with one another was during smoke breaks. She further stated this was the first time she had ever seen Resident #47 hit anyone. She reported the incident to the nurse supervisor.<br><br>An interview was conducted on 2/7/25 at 12:35 PM, with Nurse #19 who stated he was informed of the altercation between Resident #47 and Resident #17. Resident #47 was upset with Resident #17 because he would not move out of | F 600 | | |

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|---|---|---|---|
| | 345434 | A. BUILDING ______ B. WING ______ | C 02/07/2025 |

| 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 600 | Continued From page 20<br>his personal space and punched Resident #17 in the face. Nurse #19 stated the staff that was present separated the two residents immediately. Resident #47 was immediately placed on 1:1 supervision. He further stated a physical assessment was done for both residents. Resident #17's left eye was red and swollen. Nurse #19 stated he contacted the nurse practitioner and notified family of the incident. The nurse practitioner ordered x-rays to rule out any other injuries. He further stated there had been no other incidents between the two residents when the smoking environment was changed.<br><br>An interview was conducted on 2/6/25 at 4:00 PM, with the Director of Nursing who stated she was informed of the altercation between Resident #17 and Resident #47. She stated the two residents were headed to the smoking area when Resident #47 asked Resident #17 to move out of the way. Resident #17 did not move away fast enough when Resident #47 hit Resident #17 in the face. The staff present immediately separated the two residents. Nurse #19 assessed both residents for injuries and notified the nurse practitioner and the responsible parties for both residents. Resident #17's left eye was swollen. Resident #47 was immediately placed on 1:1 supervision and referred for a psychological evaluation. Psych service evaluated Resident #47 on 10/23/24 and a medication adjustment was done. Resident #47 remained at 1:1 until the medication adjustment was effective. Resident #17 was sent out for x-rays to rule out any further injuries. The results from the x-ray were negative for any other injuries. Resident #17 was also seen by psych services and there were no changes or recommendations. She stated the care plans were updated for both residents to | F 600 | | |

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|---|---|---|---|
| | 345434 | A. BUILDING ______ B. WING ______ | C 02/07/2025 |

| 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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|---|---|---|---|---|
| F 600 | Continued From page 21<br>address behaviors. The Director of Nursing stated an evaluation was done of the smoking area by management and it was determined the previous location was too small for the number of residents who smoke; therefore, the location was changed to allow all residents space to smoke in comfort. Both residents were assessed for any behavioral issues/concerns, skin assessments were done for both residents for 72 hours. There were no further incidents or changes in physical or mental well-being for either resident. The Director of Nursing stated both residents were interviewed, and Resident #17 was able to state what happened but did not express any concerns of fear of Resident #47 or any other residents. Resident #47 stated nothing happened. She reported the social service staff conducted interviews with individual residents and during resident council about abuse and safety awareness and there were no concerns from the residents. The Director of Nursing stated both residents continue to smoke at leisure and have not had any further incidents since the changes were implemented in the smoking area. All current and newly hired staff were educated on abuse/dementia training.<br><br>An interview was conducted on 2/6/25 at 5:00 PM with the current Administrator who stated the previous Administrator completed the compliance action plan and there had been no new behavior since the incident. He stated the change of environment for both residents have been beneficial in limiting the interactions with one another. He further stated the previous Administrator completed the investigation and implemented the corrective actions to monitor the smoking area and added assigned staff during scheduled smoking times. All staff have been | F 600 | | |

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|---|---|---|---|
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| 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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|---|---|---|---|---|
| F 600 | Continued From page 22 | F 600 | | |

educated on resident-to-resident behaviors, abuse, neglect in Oct 24 as well as current. The Director of Nursing and Unit managers have been monitoring all resident behaviors and completing behavior assessment and making necessary referrals to psych services for evaluation when appropriated.

A telephone interview was conducted on 2/7/25 at 10:15 AM, with the Nurse Practitioner #1 who stated she assessed Resident #17 following the altercation with Resident #47. Resident #17 complained of some pain in his face, and she ordered an x-ray to make sure there were no other injuries. She reported Resident #17 was already on scheduled pain medications and after a few days the swelling went down, and Resident #17 did not report any other concerns in relation to the incident.

The facility implemented a corrective action plan: 8/2/2024 for the Resident #52 and Resident #104 altercation and 10/20/24 for Resident #17 and Resident #47 altercation.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On 8/2/2024 at 7:30 pm, Resident #52 and Resident #104 were observed in a physical altercation and were separated by facility staff and taken to a separate area to interview.

On 8/2/2024, initial head to toe assessments were completed by facility nurse with no apparent injuries for Resident #52 and Resident #104. A follow-up skin assessment by facility nurse revealed minor injuries to Resident #52 that

| 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 02/07/2025 |

| 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 600 | Continued From page 23 | F 600 | | |

required no treatment.

On 8/2/2024, Resident #104 was placed on one-to-one supervision.

On 8/2/2024, Resident #52's representative was notified of the resident-to resident altercation. Resident #104 was his own responsible party.

On 8/2/2024, the physician was notified by facility nurse with no new orders for Resident #52 and Resident #104.

On 8/2/2024, the facility nurse interviewed known resident witnesses.

On 8/3/2024, Resident #52 and Resident #104 were re-interviewed by Director of Nursing.

On 8/3/2024, Resident witnesses were reinterviewed by Director of Nursing.

On 8/3/2024, Resident #52's physician was contacted by the Director of Nursing and new orders were received.

On 8/3/2024, Resident #52 completed a telehealth visit with the mental health physician with new orders obtained.

On 10/20/24, Resident #17 and Resident #47 were immediately separated by facility staff. Resident#47 was placed with 1:1 supervision. Resident #47 was assessed by the facility nurse on 10/20/24 with no negative findings or change of condition. Resident #17 was assessed by the facility nurse with pain and edema noted to left eye orbit and no other change of condition.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 600 | Continued From page 24<br>On 10/20/24 the provider was notified by the licensed nurse of the assessment of findings for Resident#17. An order for x-ray was obtained. Resident #47's provider was notified and there were no new orders.<br><br>On 10/20/24 Resident #17 was assessed for psychosocial harm by the licensed nurse with no ill effects. Resident #17 and Resident #47's responsible parties were notified of the incident by the licensed nurse.<br><br>On 10/21/24 Resident #47's care plan was updated to include intervention for 1:1 supervision and Resident #14's x-rays returned with no findings related to this occurrence. Psych evaluation completed 10/23/24 for Resident #17 and Resident #47.<br><br>Root cause analysis was conducted on 10/20/2024: Resident to resident altercation occurred between Resident #14 and Resident #47 in the smoking area. Resident #47 experienced frustration and tension due to overcrowding in the designated smoking space. The designated smoking area was too small to comfortably accommodate the number of residents who smoke. The facility's original space plan didn't adequately account for the number of residents who smoke and their need for personal space while smoking. The facility evaluated the current smoking area was too small which attributed to these behaviors, so the smoking area was moved to a larger area.<br><br>Address how the facility will identify other residents at risk and determine if there were any identified problems for those residents:<br>All residents were at risk. Resident interviews | F 600 | | |

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| | 345434 | A. BUILDING ______ B. WING ______ | C 02/07/2025 |

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|---|---|---|---|---|
| F 600 | Continued From page 25 | F 600 | | |

were completed with residents with a brief interview for mental status (BIMS) score of 13 or greater with no new findings on 8/3/2024 by Nurse #23 and the Director of Nursing. On 10/21/2024, Residents with a BIMS score of 10 or greater were interviewed by a Social Worker for safety with no concerns noted.

Skin checks were completed on residents with a brief interview for mental status (BIMS) score of less than 13 with no new findings on 8/3/2024 by Nurse #23. On 10/21/24 residents with a brief interview for mental status (BIMS) score of 9 or less were assessed by a licensed nurse for any injury or new skin area with no concerns notes.

Staff interviews were completed to identify any other potential resident -to-resident altercations or increased aggression with no new findings on 8/3/2024 by Nurse #23.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
Staff to report to Director of Nursing or Administrator any verbal or physical threats made by a resident.
On 8/3/2024 and 8/8/2024, all staff were educated on the abuse and neglect policy, management of problematic behaviors that included immediate action in placing a resident on 15-minute checks or one-to-one supervision and notifying the Director of Nursing and/or Administrator when a resident threatened to hurt another resident. Resident #52 and Resident #104 were to smoke in separate smoking areas and/or at different times. Resident #17 and Resident #47 were supervised smokers and would be assisted to smoke in separate smoking

| 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 02/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 600 | Continued From page 26 | F 600 | | |

areas.

On 10/20/24 staff were re-educated on the abuse policy by the facility Director of Nursing and other members of the nurse management team. The education included different types of abuse, reporting and response procedures. Staff were also educated on behavior identification, communication and intervention by the Director of Nursing. Newly hired or contracted staff will be educated on the facility abuse policy and procedure prior to accepting assignment(s). Anyone not receiving education would be removed from schedule until education was provided

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

On 8/3/202, the facility decided to monitor the performance of the correction plan by: (1) the Administrator, Director of Nursing, Assistant Administrator and/or quality assurance nurse will interview ten residents weekly for any unknown resident-to-resident threats weekly for six weeks. (2) The Director of Nursing, quality assurance nurse, and /or unit manager will audit all progress notes five times a week for five weeks for any unreported resident behavior or resident-to-resident threat. This corrective action plan will be completed 8/4/2024.

On 10/20/2024, the facility decided to monitor the performance of the correction plan by: (1) The Director of Nursing, Quality Assurance Nurse and/or Unit Manager will review progress noted to ensure aggressive behaviors have been identified and interventions are appropriate and in place 3

| 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 02/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 600 | Continued From page 27 | F 600 | | |

times a week for 6 weeks. (2) The facility Administrator will review the audit(s) and plan to identify patterns/trends during the monthly Quality Assurance and Performance Improvement meeting will be adjusted to maintain compliance at the discretion of the QAPI committee.

This Corrective Action will be completed 10/21/24.

The facility's corrective action plan with a correction date on 8/8/2024 (due to educational in-services dated 8/8/2024) and 10/21/2024 were validated onsite 2/3/2025 through 2/7/2025 by record review, observations, and interviews with residents, nursing staff, the former director of nursing, the director of nursing, and the Administrator.

Observations of the resident smoking area were conducted on 2/4/2025 through 2/7/2025 during all three shifts at various times. Resident #52 and Resident #104 were not observed in the smoking area at the same time, and Resident #17 and Resident #47 were not in the smoking area at the same time.

The resident council meeting held on 2/5/25 at 2:30 pm revealed no concerns with abuse or safety.

A review of the in-services logs dated 8/3/2024 and 8/8/2024 on abuse and neglect, managing residents with behaviors and resident-to-resident altercations included actions to immediately separate residents and notify the Administration. If a resident threats to hurt another resident, immediately place the potential victim and potential aggressor on increased monitoring

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|---|---|---|---|
| | 345434 | A. BUILDING ______ B. WING ______ | C 02/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 600 | Continued From page 28<br>every 15 minutes or one-to-one supervision. This in-service was provided to all facility staff that included dietary staff, therapy staff, nurses, nurse aides, housekeeping, activity and the administration team. A review of in-service logs confirmed staff education was initiated on 10/20/24 for all staff regarding abuse/neglect policies and procedures and behavior management.<br><br>The nursing staff confirmed during the interviews that they had received in-service training in August 2024 and October 2024 after each resident-to-resident altercation related to the Abuse policy included "abuse, neglect, reporting, documentation, behavior identification and interventions in managing residents with behaviors" and resident-to-resident altercations. They were assigned to review the handouts for the in-service prior to the training. The training was conducted in-person by the Director of Nursing, and it included multiple examples and scenarios.<br><br>A review of weekly audits dated 8/5/2024 to 9/6/2024 by the quality assurance nurse recorded interviews with ten residents related to resident-to-resident altercation and reporting resident-to-resident to the correct staff and checking progress notes for resident-to-resident altercations and reported to administration. During the audits, two roommates were identified for arguing, and the facility moved one of the residents to a different room. Otherwise, no further concerns identified during that audit. A review of the audit records dated 10/21/2024 through 11/30/2024 revealed the Director of Nursing and Unit Managers were reviewing daily nursing notes, updating care for behaviors, | F 600 | | |

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|---|---|---|---|
| | 345434 | A. BUILDING ______ B. WING ______ | C 02/07/2025 |

| 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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|---|---|---|---|---|
| F 600 | Continued From page 29<br>smoking assessments, implementation of staff 24-hours to monitor the smoking area, 24-hour reports, admission/readmission reports that would document type of resident behavior, pain assessment, notification(s) made to nurse practitioner, physician, psych service referrals, responsible parties, reviews of medication administration audit forms in real time, new orders reviews and implemented new plan(s) of care or intervention(s). The 24-hour reports and admission/readmission report and nursing notes review for all shifts were randomly audited once per week for 4 weeks. The monitoring would be ongoing through the quality assurance performance process until such that consistent substantial compliance has been achieved as determined by the committee.<br><br>The facility's corrective action plan and the compliance date of 10/21/24 were validated. | F 600 | | |
| F 655 SS=D | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders. | F 655 | | 3/4/25 |

| 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 02/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 655 | Continued From page 30<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to develop a baseline care plan within 48 hours of admission for 1 of 9 residents reviewed for new admission (Resident #382).<br>Findings included:<br><br>Resident #382 was admitted on 1/28/25. His diagnoses included influenza due to influenza virus with other respiratory manifestations, unsteadiness of feet, and muscle weakness. | F 655 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice<br>" The Director of Nursing reviewed the medical record and confirmed that Resident #382 is no longer at the facility. The facility reviewed the admission process to identify why the baseline care plan was not developed within 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 02/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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F 655

Continued From page 31

Review of Resident #382's baseline care plan initiated on 1/29/25 only included information on medication allergies and code status.

An interview was conducted on 2/06/25 at 5:04 PM with Minimum Data Set (MDS) Coordinator #1. She stated upon admission that the initial care plans were completed by the admitting nurse. After reviewing Resident #382's baseline care plan, she noted it had been opened on 1/29/25, the date after admission, but not completed and only included his allergies and code status. She explained the baseline care plan should have been completed by the admitting nurse.

An interview with the Director of Nursing (DON) was conducted on 2/07/25 at 9:20 AM. The DON stated the baseline care plans should have been completed with the admission assessment.

F 655

required timeframe.
" Completion Date: 2/24/2025

Address how the facility will identify other residents having the potential to be affected by the same deficient practice
" The Director of Nursing/designee conducted chart audits of all residents admitted within the past 30 days to ensure baseline care plans were developed within 48 hours of admission as required. For identified residents without proper baseline care plans, the MDS Coordinator/designee developed and implemented baseline care plans immediately.
" Completion Date: 2/24/2025

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
" The MDS Coordinator/designee will implement a verification process after each new admission to ensure baseline care plans are completed within 48 hours of admission. This process will include reviewing documentation and tracking baseline care plan completion status.
" The Director of Nursing/designee will provide education to all licensed nursing staff on baseline care plan requirements, completion timeframes, and documentation. Any staff who do not receive this education by the completion date will not be allowed to work until they have completed this required training. New hires will receive this education during orientation before providing direct

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|---|---|---|---|
| | 345434 | A. BUILDING ______ B. WING ______ | C 02/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| F 655 | Continued From page 32 | F 655 | resident care. Documentation of attendance will be maintained in employee training records.<br>" Completion Date: 3/4/2025<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained<br>" The MDS Coordinator/designee will conduct random audits of five (5) newly admitted residents weekly for six (6) consecutive weeks, then monthly for three (3) months to ensure baseline care plans are completed within 48 hours of admission. Any identified deficiencies will be corrected immediately, and additional education will be provided to the involved staff.<br>" Results of these audits will be reviewed and analyzed by the QAPI/QA Committee for trends and additional corrective action.<br>" This plan of correction will be monitored at the monthly QAPI/QA meeting until such time consistent substantial compliance has been met.<br>" Completion Date: 3/4/2025 and ongoing | |
| F 656 SS=B | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's | F 656 | | 3/4/25 |

| 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 02/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 656 | Continued From page 33<br>medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by: | F 656 | | |

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|---|---|---|---|
| | 345434 | A. BUILDING ______ B. WING ______ | C 02/07/2025 |

| 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 656 Continued From page 34

Based on staff interviews and record review, the facility failed to develop a comprehensive care plan that accurately reflected the services provided to a resident when it incorrectly indicated Resident #10 was receiving Hospice services. This occurred for 1 of 2 residents (Resident #10) reviewed for hydration.

The findings included:

Resident #10 was admitted to the facility on 8/26/22.

Resident #10's most recent MDS assessment was a quarterly assessment dated 12/27/24. The MDS section on "Special Treatments, Procedures, and Programs" indicated Resident #10 did not receive Hospice services.

A copy of Resident #10's current care plan was provided by MDS Coordinator #1 and MDS Coordinator #2 on 2/7/25. A review of this care plan revealed it included the following areas of focus, in part:
--Resident #10 has an Activities of Daily Living (ADL) self-care performance deficit related to disease processes that include respiratory failure, congestive heart failure, and diabetes ..."Under care of hospice." Date Initiated: 10/12/22; Revision on: 8/14/23. The resident's goal for this area of focus was last revised on 8/18/24 with a target date of 4/20/25.
--Resident #10 is at risk for nutritional problems or potential nutritional problems related to her diagnoses of respiratory failure, congestive heart failure, diabetes ..."She is now under care of hospice and has had poor po [oral] intake and may need to be fed by staff." Date Initiated: 1/11/23; Revision on: 8/2/23. The resident's goal

F 656

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice
" The MDS Coordinator reviewed Resident #10's chart and confirmed they are no longer residing at the facility.
" Completion Date: 2/24/2025

Address how the facility will identify other residents having the potential to be affected by the same deficient practice
" The MDS Coordinator/designee conducted an audit of all current residents with hospice services or hospice documentation in their care plans to ensure accuracy of documented services, specifically verifying that documented hospice services reflected current resident status and services being provided. Care plans were corrected immediately for any residents identified with inaccurate hospice service documentation.
" Completion Date: 2/24/2025

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
" The Director of Nursing/designee will provide education to all licensed nursing staff on accurate documentation of services in comprehensive care plans, including the importance of verifying current services when developing and updating care plans. Any staff who do not receive this education by the completion date will not be allowed to work until they have completed this required training.

| 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 02/07/2025 |

| 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 656 Continued From page 35

for this area of focus was last revised on 8/18/24 with a target date of 4/20/25.
--Resident #10 has pain in right knee due to history of total knee replacement and internal fixation of the proximal diaphysis of the tibia (a surgical method of physically reconnecting the bones) ..."7/25/23 admitted to hospice services." Date Initiated: 4/19/23; Revision on: 8/14/23. The resident's goal for this area of focus was last revised on 8/18/24 with a target date of 4/20/25.
--Resident #10 is at increased risk for pressure ulcer development related to disease process, decreased mobility, and moisture exposure ..."admitted to hospice 7/25/23." Date Initiated: 10/12/22; Revision on: 08/14/23. The resident's goal for this area of focus was last revised on 8/18/24 with a target date of 4/20/25.

A review of Resident #10's electronic medical record (EMR) revealed no consultations or notes could be identified from 12/1/23 (the date of the facility's last recertification) through the date of the review on 2/7/25 to indicate the resident received Hospice services.

An interview was conducted on 2/7/25 at 8:35 AM with MDS Coordinator #1 and MDS Coordinator #2. Upon request, the MDS Coordinators reviewed Resident #10's electronic medical record (EMR), MDS assessments, and comprehensive care plan. MDS Coordinator #1 reported from what she could recall, the resident may have had a Hospice consultation at one point in time. From the review of Resident #10's EMR, however, the MDS Coordinators agreed they did not see where any Hospice services had been provided to the resident. When asked if Resident #10's care plan should reflect that she was receiving Hospice services, the MDS

F 656

New hires will receive this education during orientation before providing direct resident care. Documentation of attendance will be maintained in employee training records.
" Completion Date: 3/4/2025

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained
" The Director of Nursing/designee will conduct random audits of five (5) residents' comprehensive care plans, three (3) times per week for six (6) consecutive weeks, then monthly for three (3) months to ensure accuracy of documented services. These audits will verify that all documented services in the care plans accurately reflect current services being provided to residents. Any identified deficiencies will be corrected immediately, and additional education will be provided to the involved staff.
" Results of these audits will be reviewed and analyzed by the QAPI/QA Committee for trends and additional corrective action.
" This plan of correction will be monitored at the monthly QAPI/QA meeting until such time consistent substantial compliance has been met.
" Completion Date: 3/4/2025 and ongoing

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| F 656 | Continued From page 36<br>Coordinators reported it should not. Upon further inquiry, MDS Coordinator #2 reported staff from each discipline contributed to completing residents' care plans. The MDS Coordinators added that a resident's comprehensive care plan should be reviewed "when anything changes with the patient [resident] and then quarterly."<br><br>An interview was conducted on 2/7/25 at 11:01 AM with the facility's Administrator. During the interview, the Administrator stated, "The care plan needs to be reflective of the MDS to meet the needs of the resident." | F 656 | | |
| F 658 SS=D | Services Provided Meet Professional Standards<br>CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and record review, the facility staff failed to provide care according to professional standards by borrowing medication from one resident (Resident #14) to give to another (Resident #8) for 1 of 5 residents observed during the medication administration observation.<br><br>The findings included:<br><br>Resident #8 was admitted to the facility on 2/8/21 with cumulative diagnoses which included hemiplegia (severe or complete paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction | F 658 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice<br>" The Director of Nursing immediately completed a medication review for both Resident #8 and Resident #14 to ensure all current medications were available and being administered according to physician orders. The Director of Nursing/designee contacted the pharmacy to obtain the correct medication for Resident #8 and verified that Resident #14's medication supply was replenished to ensure both residents had their own prescribed | 3/4/25 |

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F 658

Continued From page 37

(an ischemic stroke where blood flow to the brain has been interrupted) affecting the left dominant side, and atrial fibrillation (a type of irregular heart rhythm).

Resident #14 was admitted to the facility on 2/17/22 with cumulative diagnoses which included a history of pulmonary embolism.

On 2/5/25 at 9:08 AM, a continuous observation was conducted as Nurse #3 began to prepare thirteen (13) medications (meds) for administration to Resident #8. After the nurse had pulled 9 of the 13 medications, Nurse #3 began to look through other residents' meds stored on the medication cart. On 2/5/25 at 9:24 AM, Nurse #3 stated she had "to find one" as she was observed to take one tablet of 5 milligrams (mg) apixaban (an oral anticoagulant) dispensed from the pharmacy for Resident #14 to give to Resident #8. Afterwards, Nurse #3 completed pulling the medications for Resident #8 and was observed as she administered them to the resident.

Resident #8's current physician's orders revealed her medication orders included 5 mg apixaban to be given as 1 tablet by mouth every 12 hours related to hemiplegia and hemiparesis following cerebral infarction affecting left dominant side and atrial fibrillation (Start Date 2/8/21).

Resident #14's current physician's orders revealed her medication orders also included 5 mg apixaban to be given as 1 tablet by mouth every 12 hours for anticoagulation (Start Date 5/30/24).

An interview was conducted on 2/5/25 at 12:14

F 658

medications available for administration.
" Completion Date: 2/24/2025

Address how the facility will identify other residents having the potential to be affected by the same deficient practice
" The Director of Nursing/designee conducted a facility-wide audit of all current residents' medication supplies and medication administration records to ensure each resident had their own prescribed medications available and that no medications were being borrowed between residents.
" Completion Date: 2/24/2025

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
" The Director of Nursing/designee will review medication omissions and unavailable medications during daily clinical meetings to ensure timely pharmacy ordering and delivery of medications. This review process will verify medication availability and maintain proper administration practices for all residents.
" The Director of Nursing/designee will provide education to all licensed nursing staff and medication aides regarding professional standards for medication administration, including the prohibition of borrowing medications between residents, proper procedures for obtaining medications from pharmacy, and steps to take when medications are not available. Staff will not be allowed to work until they

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F 658 Continued From page 38

PM with Nurse #3. During the interview, Nurse #3 was asked about the borrowing of apixaban from Resident #14 to give to Resident #8. The nurse stated that if a resident was out of a medication, nursing staff was supposed to order it from the pharmacy. However, she also reported that as an agency nurse (temporary staff member), she felt it was her responsibility to give all the medications to a resident and then reorder more if the supply of that medication was low (or out). When asked, Nurse #3 reported she had been coming to work at this facility approximately once a week for two months. The nurse reported she typically floated to work as a hall nurse on various halls.

An interview was conducted on 2/5/25 at 3:43 PM with the facility's Director of Nursing (DON). During the interview, the borrowing of apixaban from one resident to give to another resident was discussed. The DON responded by stating, "We can't do that." The DON reported that if an agency (or staff) nurse did not know what to do if a resident ran out of his/her prescribed medication, the nurse could ask for assistance from a Unit Manager, the Quality Assurance (QA) Nurse, or the DON herself. The DON reported she was fairly certain apixaban was readily available in the facility's automated emergency medication box. When asked if she thought the borrowing of medications was consistent with the provision of care in accordance with professional standards, the DON agreed it was not.

A follow-up interview was conducted on 2/7/25 at 11:45 AM with the DON. At that time, the DON reported Resident #8's apixaban could have been obtained from the facility's emergency medication box (as 2 - 2.5 mg tablets of apixaban). She

F 658

have received the required training, and documentation of attendance will be maintained in employee training records.
" Completion Date: 3/4/2025

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained
" The Director of Nursing/designee will conduct random audits of ten (10) residents' medication supplies and medication administration records three (3) times per week for six (6) consecutive weeks, then monthly for three (3) months to ensure compliance with medication administration standards. These audits will verify that each resident has their own prescribed medications available and that no medications are being borrowed between residents. Any identified deficiencies will be corrected immediately, and additional education will be provided to the involved staff.
" Results of these audits will be reviewed and analyzed by the QAPI/QA Committee for trends and additional corrective action.
" This plan of correction will be monitored at the monthly QAPI/QA meeting until such time consistent substantial compliance has been met.
" Completion Date: 3/4/2025 and ongoing

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| F 658 | Continued From page 39<br>provided an "Active Inventory" list of medications currently available in the emergency medication box. These medications included 14 tablets of 2.5 mg apixaban. | F 658 | | |
| F 688<br>SS=D | Increase/Prevent Decrease in ROM/Mobility<br>CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident interviews, staff interviews and record review, the facility failed to apply a left hand splint for 1 of 1 resident (Resident #47) reviewed for contractures.<br><br>The findings included:<br><br>Resident #47 was admitted to the facility on 6/3/22 with diagnoses of hypertension, diabetes, cerebral vascular accident, and left-hand contracture/hemiparesis. | F 688 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice<br>" The Unit Manager immediately assessed Resident #47's left hand contracture status and applied the prescribed hand splint according to the physician's orders. The Unit Manager also reviewed the resident's splint application schedule and current range of motion | 3/4/25 |

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F 688

Continued From page 40

Review of quarterly Minimum Data Set(MDS) assessment dated 12/15/24 indicated Resident #47 was severely cognitively impaired. The MDS coded Resident #47 with left hand contracture.

Review of the physician order dated 9/27/23 revealed please assist in the application of the left palmar guard to left hand. Resident #47 may wear the palmar guard all day except during the care and meals. Resident #47 may remove guard at his discretion. Check for signs and symptoms of skin breakdown and discoloration prior to and after administration. Every shift the palmar guard may be laundered or hand washed.

Review of the occupational therapy discharge summary on 9/8/23 revealed Resident#47 was to wear left hand splint 6 hours without adverse reaction. This included no pain and no skin irritation. Resident #47 has demonstrated tolerance to left hand splint for approximately 8 hours. The discharge goal dated 9/7/23 revealed Resident #47 required assistance to apply splint. Resident #47 was able to take off splint independently due to discomfort and during meals/care.

Review of the Medication Administration Records (MAR) December 1, 2024 through February 1, 2025 revealed Nurse #20 documented the repetitive statement that read: please assist in application of left palmar guard to left hand. Pt may wear the palmar guard all day except during care and meals. Pt may remove guard at his discretion. Check for signs and symptoms of skin breakdown and discoloration prior to and after administration. Every shift the palmar guard may be laundered in laundry or hand washed. The

F 688

status to ensure appropriate positioning.
" Completion Date: 2/24/2025

Address how the facility will identify other residents having the potential to be affected by the same deficient practice
" The Director of Nursing/designee conducted a comprehensive audit of all current residents with prescribed splints to ensure proper application, documentation, and adherence to physician orders for splinting schedules and range of motion programs.
" Completion Date: 2/24/2025

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
" The Unit Manager/designee will incorporate splint application verification into daily clinical rounds and document findings on a splint application tracking log. The Unit Manager/designee will review compliance during daily clinical meetings to ensure proper application and documentation of prescribed splints.
" The Director of Nursing/designee will provide education to all nursing staff regarding proper splint application, documentation requirements, and the importance of following prescribed splinting schedules to prevent further contractures. Staff will not be allowed to work until they have received the required education, and documentation of attendance will be maintained in employee training records.
" Completion Date: 3/4/2025

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| F 688 | Continued From page 41<br>palmar guard was not in use today. There was no documentation in the record when the palmar was applied, refused or removed.<br><br>Several attempts were made to contact Nurse #20 who was not available for interview.<br><br>An observation was conducted on 2/3/25 at 11:00 AM, Resident #47 was observed rolling around the facility without the left hand palmar guard in place. There was a beige foam palmar guard available in the top drawer of the dresser.<br><br>An observation of Resident #47 on 2/4/25 at 8:45 AM revealed the left hand had no palmar guard/splint in place.<br><br>An observation was conducted on 2/4/25 at 11:03 AM in conjunction with an interview with Resident #47 who was sitting at bedside with his left hand clenched. The left hand palmar guard/splint was in the top drawer of the dresser with Resident #47's name on it. Resident #47 stated he needed assistance to apply the splint because he was unable to put the splint on himself. He stated that staff had not put the splint on in a long time.<br><br>An observation was conducted on 2/4/25 at 2:30 PM, Resident #47 was in the smoke area and the left-hand palm splint was not in place.<br><br>An observation was conducted on 2/5/24 at 8:20 AM, Resident #47 was lying in bed without the left hand palmar guard/splint. The splint was in the top dresser drawer.<br><br>An observation was conducted on 2/5/24 at 10:00 AM, Resident #47 was rolling around the halls in the facility without the left hand palmar | F 688 | Indicate how the facility plans to monitor its performance to make sure that solutions are sustained<br>" The Director of Nursing/designee will conduct random audits of five (5) residents with prescribed splints three (3) times per week for six (6) consecutive weeks, then monthly for three (3) months to ensure compliance with splint application and documentation requirements. These audits will verify proper splint application, adherence to prescribed schedules, and appropriate documentation. Any identified deficiencies will be corrected immediately, and additional education will be provided to the involved staff.<br>" Results of these audits will be reviewed and analyzed by the QAPI/QA Committee for trends and additional corrective action.<br>" This plan of correction will be monitored at the monthly QAPI/QA meeting until such time consistent substantial compliance has been met.<br>" Completion Date: 3/4/2025 and ongoing | |

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| F 688 | Continued From page 42 | F 688 | | |

guard/splint.

An observation was conducted on 2/5/25 at 1:30 PM, Resident #47 was at the nursing station and the left hand palmar guard/splint was not in place.

An interview was conducted on 2/6/25 at 10:20 AM in conjunction with a record review with the Unit Manager #1 who reviewed the chart and confirmed there was a copy paste of the physician orders but no documentation of when the splint was applied, refused or removed. The Unit Manager #1 confirmed the Medication Administration Record documentation was only done by Nurse #20 and she was unable to determine when the splint was applied or removed throughout the day. The Unit Manager#1 stated she was unaware of the location of Resident #47's left hand palmar guard/splint and only observed Resident #47 wearing a glove.

An observation was conducted on 2/6/25 at 10:25AM, Resident #47 was rolling around the facility in his wheelchair and the left hand palmar guard/splint was not in place.

An interview was conducted on 2/6/25 at 10:33 AM with Nurse Aide #7 who stated she had not ever seen the resident with a splint on. She looked through the top drawer of the dresser and found a beige foam splint in the drawer. Nurse Aide #7 stated she had not seen that splint on Resident #47, nor had she applied the splint. She further stated she was unaware of who was responsible for documenting the application or how long Resident #47 should wear the splint.

An interview was conducted on 2/6/25 at 10:36

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| F 688 | Continued From page 43 | F 688 | | |

AM, with the Smoke Aide #2 who stated that rehabilitation therapy staff was responsible for applying the hand splint. She stated she was not aware if the resident was consistently wearing the splint.

An interview was conducted on 2/6/25 at 10:45 AM, with Nurse #21 who stated she was aware the resident should wear the splint all day, but she was unaware of the location of the splint. Nurse #21 further stated Resident #47 was non-compliant and she was unaware if therapy was notified that the resident was not wearing the splint.

An interview was conducted on 2/6/25 at 10:56 AM, in conjunction with a record review with the Rehabilitation Director who stated the left-hand palm splint order had been in place since 9/8/23. The nursing staff and/or nurse aide were responsible for applying the splint daily per physician orders. Nursing should document when the splint was applied, refusal and removal. He stated he was unaware Resident #47 was not wearing the splint. The Rehabilitation Director reviewed the record and confirmed the Medication Administration Record(MAR), and nursing notes did not document when the splint was applied, refused or removed. The record confirmed repetitive statement of the physician order, and the care plan was not updated to reflect the splint application. He further stated the resident would need to be re-evaluated.

An interview was conducted on 2/6/25 at 12:07 PM, in conjunction with a record review with the Director of Nursing who reviewed the record and confirmed there was no documentation of when Resident #47's splint was applied, refused or

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| F 688 | Continued From page 44<br>removed. She further stated nursing and/or nurse aide was responsible for the application of the splint in accordance with the physician orders. The nurses were responsible for documenting on the MAR when the splint was applied, refused or removed.<br><br>An interview was conducted on 2/7/25 at 12:00 PM with the Administrator who stated he expected the nursing staff to follow the physician orders and therapy instructions for the application of the splint, document appropriately on the Medication Administration Record (MAR) and the Minimum Data Set (MDS) Coordinators to update the resident's care plan. | F 688 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, resident and staff interviews, the facility failed to supervise smoking for a resident who required supervision when smoking and failed to secure smoking materials (cigarettes) for 1 of 4 residents (Resident #65) reviewed for safe smoking.<br><br>Findings included:<br><br>Resident was admitted on 12/2/24 with diagnoses | F 689 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice<br>" The Director of Nursing secured all smoking materials for Resident #65 by removing them from the resident's possession and implementing secure storage at the nurses' station. The Unit Manager immediately implemented | 3/4/25 |

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| F 689 | Continued From page 45<br>that included type 2 diabetes mellitus, peripheral vascular disease, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia and dependent on supplemental oxygen.<br><br>Review of the admission Smoking Safety Evaluation dated 12/2/24 read in part "based on the direct observation the resident smokes only in designated area, was able to safely light smoking material, holds smoking materials safely, disposes of ashes in ashtray, and responds quickly to fallen ashes." The evaluation indicated Resident #65 used oxygen and removed tubing/not brought into smoking area. The assessment also indicated the resident followed smoking guidelines per policy, was able to call for emergency assistance and returned smoking materials for storage. Resident #65 was evaluated as unsupervised smoker based on the observation.<br><br>Review of the admission Minimum Data Set (MDS) assessment dated 12/8/24 revealed the resident was assessed as cognitively intact. Resident #65 was assessed as a smoker and was on oxygen therapy.<br><br>Review of the Smoking Safety Evaluation date 12/12/24 revealed Resident #65 was a smoker. Direct observation indicated that the resident does not smoke in the designated areas. The resident was able to safely light smoking material, able to hold smoking materials safely, able to dispose of ashes in ashtray, able to respond quickly to fallen ashes and able to call for emergency assistance. Assessment also indicated that Resident #65 does not return smoking materials for storage. The summary of the evaluation indicated that for the resident's | F 689 | supervised smoking for Resident #65 and conducted a smoking assessment reviewing current smoking status, safety awareness, and supervision needs.<br>" Completion Date: 2/24/2025<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice<br>" The Director of Nursing/designee conducted a facility-wide audit of all current residents who smoke to identify those requiring supervision while smoking and those requiring secured storage of smoking materials. This audit included a review of smoking assessments, observation of current smoking practices, and verification of proper storage of smoking materials.<br>" Completion Date: 2/24/2025<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur<br>" The Director of Nursing/designee will implement a supervised smoking program by updating the daily assignment sheets to identify which staff members are responsible for supervised smoking activities on each shift. The Unit Manager/designee will maintain a current list of residents requiring smoking supervision at the nurses' station. A sign-out log will be maintained at the nurses' station for all smoking materials belonging to residents who require supervised smoking, requiring staff signature for distribution and return of | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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F 689 Continued From page 46

safety, Resident #65 was assessed as a supervised smoker. The smoking material was stored by the facility. The resident was provided with education on smoking (Facility policy/procedure). Resident was provided with the resident's smoking safety evaluation results and care plan was initiated.

Review of the care plan dated 12/19/24 revealed the resident was care planned for smoking. Interventions indicated a care conference was necessary to address unsafe smoking practice. The resident was educated on facility's smoking policies and protocols. Inventions also included monitoring/ documenting and reporting any instances of noncompliance. The resident required supervision while smoking.

During an observation on 2/4/25 at 5:25 AM, Resident #65 was observed in the smoking area, sitting in her wheelchair smoking a cigarette. The resident was not supervised by any staff. She was the only resident in the smoking area. Resident was not using any oxygen. Resident #65 indicated she did not need any supervision during smoking.

During an interview on 2/4/25 at 6:19 AM, Smoking Aide #1 stated she allowed Resident #65 to go out to the smoking area early that morning (2/4/25) and had to leave as she had to use the restroom (time unknown). Smoking Aide #1 further stated she notified another staff member to observe the resident as she needed to go on a break. Smoking Aide #1 indicated the resident was an unsupervised and safe smoker and usually had her smoking materials with her. Smoking Aide #1 indicated the residents were allowed to smoke anytime and the assigned

F 689

these materials.
" The Director of Nursing/designee will provide education to all nursing staff regarding smoking safety requirements, including proper supervision of residents while smoking, secure storage of smoking materials, and documentation requirements. Any staff who do not receive this education by the completion date will not be allowed to work until they have completed this required training. New hires will receive this education during orientation before providing direct resident care. Documentation of attendance will be maintained in employee training records.
" Completion Date: 3/4/2025

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained
" The Director of Nursing/designee will conduct random audits of five (5) residents who smoke three (3) times per week for six (6) consecutive weeks, then monthly for three (3) months to ensure compliance with smoking supervision requirements and proper storage of smoking materials. These audits will include direct observation of smoking activities, verification of proper supervision, and review of smoking material storage and sign-out documentation. Any identified deficiencies will be corrected immediately, and additional education will be provided to the involved staff.
" Results of these audits will be reviewed and analyzed by the QAPI/QA

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 689 | Continued From page 47<br>Smoking Aide had access to locked box with smoking material (cigarettes and lighter). She indicated there was a list of residents' names who smoked indicating if they were supervised or unsupervised smokers.<br><br>During an interview on 2/4/25 at 6:24 AM, Nurse Aide (NA) 5 indicated she was notified by the Smoking aide #1 prior to her leaving for a break. NA #5 stated she sat inside the dining hall for some time while the resident was smoking outside in the smoking area and later left as she had to attend to one of her assigned residents. NA #5 further stated she did not know which residents needed supervision and which residents did not. She indicated she assumed Resident #65 was a safe smoker and needed no supervision, as the resident carried her own smoking material.<br><br>During an observation and interview on 2/4/25 at 6:43 AM, Resident #65 was observed having an oxygen concentrator running at (3) Liters/ minute (L/min) via Nasal cannula (N/C). Resident #65 stated she was a smoker but does not take her portable oxygen concentrator with her when she goes out to smoke. She stated she was aware of the dangers related to smoking with oxygen. Resident #65 indicated she had not had any incident like burns during smoking. When asked if she was supervised during smoking, resident stated she was not usually supervised during smoking. Resident #65 indicated the Smoking Aide had let her out to smoke around 5:00 AM that morning (2/4/25). The resident further indicated she was left alone in the smoking area to smoke and was informed that aide was leaving for a bathroom break. The resident stated she stored her cigarettes in a box inside the table | F 689 | Committee for trends and additional corrective action.<br>" This plan of correction will be monitored at the monthly QAPI/QA meeting until such time consistent substantial compliance has been met.<br>" Completion Date: 3/4/2025 and ongoing | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| F 689 | Continued From page 48 | F 689 | | |

drawer in her room. The resident later indicated that her cigarettes were in her bag as she had just gone out to smoke and would be going out again to smoke soon. The resident had a red bag hanging on her wheelchair that had cigarettes in it. The resident indicated she does not take her portable oxygen concentrator with her when she smokes.

During an observation on 2/4/25 at 7:32 AM, Resident #65 was observed self-propelling her wheelchair to the smoking area, carrying her red bag, and portable oxygen concentrator. Resident #65 removed her portable oxygen concentrator in the dining room and placed it near the piano. She then removed the cigarette packet from the red bag and proceeded to go out to the smoking area. Outside in the smoking area, the resident was assisted by staff in lighting the cigarette.

During an interview on 2/4/25 at 7:35 AM, Smoking Aide #2 stated the cigarettes and lighter for the residents were stored in a locked box. Smoking Aide #2 indicated Resident #65 was an unsupervised smoker and could keep her cigarettes with her. Smoking Aide #2 further indicated she usually assisted Resident #65 with lighting the cigarette. She indicated that the resident does not wear her portable oxygen concentrator near the smoking area.

During an interview on 2/4/25 at 8:25AM, the Administrator and Director of Nursing (DON) were made aware of the incident on 2/4/25. The Administrator indicated that the residents should not be having any smoking material on them regardless of smoking status. All smoking material should be placed in a locked box near the smoking area. The Smoking Aides were

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| --- | --- | --- | --- | --- |
| F 689 | Continued From page 49<br>responsible for providing the smoking materials to the residents. The facility had 24-hour smoking aides available for residents.<br><br>During an interview on 2/6/25 at 10:20 AM, Unit Manager #4 stated Resident #65 was assessed as unsupervised smoker when she was initially admitted to the facility. Unit Manager #4 indicated she completed a smoking reassessment for the resident and Resident #65 was marked as supervised smoker due to noncompliance with policy and risk due to use of oxygen. The corrective actions taken due to her noncompliance were to make the resident a supervised smoker and ensure the resident does not have possession of any smoking materials. The resident was reeducated on facility smoking policy and risk of smoking with oxygen was discussed. The Unit Manager indicated all Smoking Aides should ensure that the smoking material were returned and should ensure residents were monitored during smoking if they were assessed as supervised smokers. The Unit Manager #4 stated she periodically asked the resident if she had any smoking material on her and the resident had denied having possession of any smoking materials. The Unit Manager indicated she was unsure if this change was communicated to the Smoking Aides.<br><br>During an interview on 2/6/25 at 10:42 AM, the Director of Nursing (DON) explained Resident #65 was changed to a supervised smoker as she was observed smoking in a non-smoking area. The resident was reeducated on the smoking policy and educated on handing over the smoking material to the Smoking Aides after smoking. The DON indicated that the Smoking Aides had a list of residents who smoked and if they were | F 689 | | |

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|---|---|---|---|
| | 345434 | A. BUILDING ______ B. WING ______ | C 02/07/2025 |

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|---|---|---|---|---|
| F 689 | Continued From page 50 supervised smoker or not. The Smoking Aides were supposed to collect all smoking materials when the residents return from the smoking area. The smoking materials were locked up so that no residents has access to the smoking materials.<br><br>During an interview on 2/7/25 at 11:42 AM the Administrator stated the Unit Manager does periodically follow up with Resident #65 regarding having possession of smoking materials, which the resident denies. The Administrator stated it was his expectation that all smoking materials (cigarettes and lighters) were maintained by facility and be provided to the residents when they go out to smoke. | F 689 | | |
| F 693 SS=D | Tube Feeding Mgmt/Restore Eating Skills<br>CFR(s): 483.25(g)(4)(5)<br><br>§483.25(g)(4)-(5) Enteral Nutrition<br>(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and<br><br>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, | F 693 | | 3/4/25 |

| 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 02/07/2025 |

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|---|---|---|---|---|
| F 693 | Continued From page 51<br>diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and staff interviews, the facility failed to label the bag of ready to hang prefilled enteral formula (a liquid nutritional product that is delivered into the gastrointestinal tract) that was infusing through a gastrotomy tube with the date, time and initials of the nurse that started the new bag of enteral formula for 1 of 3 residents reviewed for gastrostomy enteral feedings (Resident #482).<br><br>Findings included:<br><br>Manufacturer's instructions for the ready to hang prefilled enteral formula stated the enteral formula could hang safely up to 48 hours.<br><br>The facility's "Enteral Feeding" policy dated revised May 2014 stated to document on the enteral formula label initials, date, time that the enteral formula was hung/administered and initial that the enteral formula label was checked against the physician order.<br><br>Resident #482 was admitted to the facility on 12/13/2024 with diagnoses including cerebral vascular accident (stroke) and aphasia (inability to speak).<br><br>The admission Minimum Data Set (MDS) dated 12/19/2024 indicated Resident #482 was severely cognitively impaired and required total assistance with all activities of daily living.<br><br>Nursing documentation recorded on 1/21/2025 Resident #482 was transferred to the local | F 693 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice<br>" The Unit Manager immediately assessed Resident #482's tube feeding setup, ensuring the enteral formula bag was labeled with the date, time, and nurse's initials. The Unit Manager/designee verified the formula type, rate, and administration matched the physician's orders and care plan to ensure the resident's safety. The improperly labeled enteral formula bag was discarded and replaced with a new bag that was properly labeled with the date, time, initials, rate, and other required information.<br>" Completion Date: 02/24/2025<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice<br>" The Director of Nursing/designee conducted a facility-wide audit of all current residents receiving enteral nutrition via gastrostomy tubes to ensure their enteral formula bags were properly labeled with the date, time, and nurse's initials. This review included verification that all current enteral feeding setups matched physician orders.<br>" Completion Date: 02/24/2025<br><br>Address what measures will be put into | |

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|---|---|---|---|
| | 345434 | A. BUILDING ______ B. WING ______ | C 02/07/2025 |

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|---|---|---|---|---|
| F 693 | Continued From page 52<br>hospital for evaluation for possible gastrostomy tube placement due to declining health.<br><br>Resident #482 was re-admitted to the facility on 1/28/2025.<br><br>Physician orders dated 1/30/2025 included an order for an enteral formula at 55 milliliters (ml) per hour continuous via gastrostomy tube.<br><br>Resident #482's February 2025 Medication Administration Record (MAR) recorded Resident #482 was receiving enteral feeding at 55 ml/hour on 2/2/2025 at10:06 pm by Nurse #15 and on 2/5/2025 at 4:37 am by Nurse #16.<br><br>On 2/3/2025 at 11:34 am, Resident #482 was observed receiving a ready to hang prefilled bag of enteral formula through a gastrotomy tube at 55 ml per hour. There was no date, time and nurse's initials on the label of the enteral formula bag recording when the enteral formula was started for Resident #482. There was 100 ml of enteral formula observed in the bag.<br><br>On 2/3/2025 at 11:57 am, Nurse #9 entered Resident #482's room with the surveyor to observe Resident #482's ready to hang prefilled bag of enteral formula and stated the enteral formula was started prior to Nurse #9 starting her shift (7:00 am to 7:00 pm) and there was no information on the label of the enteral formula to determine when the enteral formula was started. She explained the nurse starting a new bag of enteral formula was to write the time and date when the enteral formula was started. She further stated based on the information on the enteral formula bag, the enteral formula could infuse 48 hours after connection to the gastrostomy tube. | F 693 | place or systemic changes made to ensure that the deficient practice will not recur<br>" The Unit Manager/designee will incorporate enteral feeding setup verification into daily clinical rounds, including checking that all enteral formula bags are properly labeled with the date, time, and nurse's initials. This will be reviewed during daily clinical meetings to ensure ongoing compliance with labeling requirements.<br>" The Director of Nursing/designee will provide education to all licensed nursing staff regarding proper labeling requirements for enteral formula bags, including the requirement to document the date, time, and nurse's initials when hanging new formula bags. Any staff who do not receive this education by the completion date will not be allowed to work until they have completed this required training. New hires will receive this education during orientation before providing direct resident care. Documentation of attendance will be maintained in employee training records.<br>" Completion Date: 3/4/2025<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained<br>" The Director of Nursing/designee will conduct random audits of five (5) residents receiving enteral nutrition three (3) times per week for six (6) consecutive weeks, then monthly for three (3) months to ensure compliance with enteral formula bag labeling requirements. These audits | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|---|---|---|

F 693

Continued From page 53

Attempts to interview Nurse #15, who was assigned to Resident #482 on 2/2/2025 from 7:00pm to 7:00 am, were unsuccessful.

On 2/6/2025 at 11:44 am after Nurse #13 completed gastrostomy care, Resident #482's ready to hang prefilled bag of enteral formula was observed with no date, time and initials on the label, and there was 1200 ml of enteral formula in the bag. Nurse #13 stated Resident #482's new bag of enteral feeding was started prior to her reporting to work on 2/6/2025 at 7:00 am on the night shift. She stated nurses were to record the date and time on the label when hanging a new bag of enteral formula.

Attempts to interview Nurse #16, who was assigned to Resident #482 on 2/5/2025 from 7:00 pm to 7:00 am, were unsuccessful.

On 2/7/2025 at 4:25 pm in a follow up interview with Nurse #13, she explained the only way nurses knew when the bag of ready to hand prefilled enteral formula was connected to Resident #482 for administration was by the date and time recorded on the enteral formula label. She further explained the time documented on Resident #482's MAR indicated the enteral formula was infusing as ordered by the physician, not the time the enteral formula was started.

In an interview with the Director of Nursing on 2/7/2025 at 5:30 pm, she stated enteral formula hung for 24 hours and nurses should always label Resident #482's enteral formula bag with the date, time, and initials to communicate when a new bag of enteral formula was started for administration.

F 693

will verify the presence of date, time, and nurse's initials on all current enteral formula bags. Any identified deficiencies will be corrected immediately, and additional education will be provided to the staff involved.

" Results of these audits will be reviewed and analyzed by the QAPI/QA Committee for trends and additional corrective action.

" This plan of correction will be monitored at the monthly QAPI/QA meeting until such time consistent substantial compliance has been met.

" Completion Date: 3/4/2025 and ongoing

| 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 02/07/2025 |

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| F 726 SS=J | Competent Nursing Staff<br>CFR(s): 483.35(a)(3)(4)(c)<br><br>§483.35 Nursing Services<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.<br><br>§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.<br><br>§483.35(c) Proficiency of nurse aides.<br>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, observations, and interviews with staff and Medical Director, the facility failed to provide an agency nurse (Nurse #1) with orientation and training to meet residents' care needs, including education and verification | F 726 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice<br>" At approximately 7:00 AM on | 3/4/25 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345434 | A. BUILDING ______<br>B. WING ______ | C<br>02/07/2025 |

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| F 726 | Continued From page 55<br>of the nurse's competency on glucometer (blood glucose meter) disinfection. Nurse #1 used a shared glucometer without disinfecting the meter between residents for 1 of 3 residents (Resident #107) who was observed to have her blood glucose checked. This occurred while there were 18 residents identified with a known bloodborne pathogen in the facility. There was a high likelihood that a resident without an existing blood borne pathogen could be exposed to a bloodborne pathogen as a result of staff not using the resident's dedicated glucometer, not knowing how to effectively clean and disinfect a glucometer, and staff not handling and storing the glucometer in a method to protect against cross-contamination via contact with other meters or equipment. Also, Nurse #2 (an agency nurse) failed to demonstrate competency with the disinfection of individually assigned glucometers stored outside of the residents' rooms in accordance with the instructions provided by the manufacturer of the disinfectant wipes for 2 of 3 residents (Residents #66 and #93) observed to have their blood glucose levels checked. This occurred for 2 of 2 nurses reviewed for training and competency (Nurse #1 and Nurse #2).<br><br>Immediate jeopardy began on 2/4/25 when Nurse #1 failed to demonstrate competency as he used a glucometer dedicated to Resident #134 to check Resident #107's blood glucose without disinfecting the shared glucometer between residents. Immediate jeopardy was removed on 2/6/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal | F 726 | 02/04/2025, upon discovery of the incident, Nurse #1 was immediately removed from resident care duties.<br>" The Director of Nursing contacted Nurse #1 by telephone regarding the requirement to complete comprehensive glucometer competency validation before accepting any future assignments at the facility.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice<br>" All residents requiring blood glucose checks were identified as being at risk.<br>" An audit was conducted by the Director of Nursing and nursing unit coordinators on 02/04/2025 that identified all facility residents requiring blood glucose checks and confirmed the presence of residents with blood borne pathogens, creating risk for cross-contamination.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur<br>" The following systemic changes have been implemented as of 02/05/2025:<br>" Comprehensive Glucometer Training and Competency Program: All licensed nurses (including facility staff and agency staff) must complete the following training and demonstrate competency before performing blood glucose monitoring: a. Required Equipment and Supplies:<br>" Gloves<br>" Glucometer | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345434 | A. BUILDING ______ B. WING ______ | C 02/07/2025 |

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|---|---|---|---|---|
| F 726 | Continued From page 56<br>harm that is not immediate jeopardy) for finding #2 and for the facility to complete agency and employee staff training with monitoring to ensure appropriate interventions are put into place.<br><br>The findings included:<br><br>This tag is cross referred to:<br><br>F880<br><br>Based on record reviews, observations, and interviews with staff and Medical Director, the facility staff failed to disinfect a shared blood glucose meter (glucometer) between residents for 1 of 3 residents (Resident #107) observed to have her blood glucose (sugar) level checked. This occurred while there were 18 residents identified with a known bloodborne pathogen in the facility. Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-registered disinfectant in accordance with the manufacturer of the glucometer potentially exposes residents to the spread of bloodborne infections. Care must also be taken by personnel handling and storing glucometers to protect the glucometers against cross-contamination via contact with other meters or equipment. Also, the facility failed to disinfect individually assigned glucometers stored outside of the residents' rooms in accordance with the instructions provided by the manufacturer of the disinfectant wipes for 2 of 3 residents (Residents #66 and #93) observed to have their blood glucose levels checked. | F 726 | " Alcohol pads<br>" Single-use lancet<br>" Blood glucose testing strips<br>" Disinfecting wipes<br>" Paper towels or tissues<br>" b. Complete Glucometer Procedure and Cleaning Steps:<br>" Obtain needed equipment and supplies<br>" Perform hand hygiene<br>" Explain the procedure to the resident<br>" Provide privacy<br>" Don gloves<br>" Obtain capillary blood glucose sampling<br>" Remove and discard gloves, perform hand hygiene prior to exiting the room<br>" Retrieve (2) disinfectant wipes from container<br>" Using the first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer<br>" After cleaning, disinfect with second wipe, maintaining 3-minute wet contact time. Allow the glucometer to air dry<br>" Discard disinfectant wipes in waste receptacle<br>" Perform hand hygiene<br>" Ensure glucometer is stored in individual plastic bag for each resident to prevent cross contamination<br>" Place clean dry paper towel or tissue under glucometer before placing on resident table or on top of medication cart to prevent contamination<br>" Competency Validation Process: Direct observation by nurse management of: | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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F 726

Continued From page 57

1. An interview was conducted on 2/4/25 at 6:17 AM with Nurse #1. When Nurse #1 was asked how long he had worked at the facility, he stated this was his first week. Upon further inquiry, the nurse reported he received a "short" orientation from facility "for agency nurses."

On 2/4/25, the facility provided a copy of the orientation packet given to agency nurses when they first began working at the facility. A review of the "Information Packet for Registry Nurses" revealed it contained information on the following topics: Welcome to [Name of Facility]; Important Guidelines (including dress code, personal devices, medication protocol, supplies, and identification); Admission Assessment (indicating the admission documentation required); Nurse Responsibilities in Admission; Daily Responsibilities; and Documentation Expectations. The orientation packet did not include any information about either the disinfection or storage of glucometers.

During an interview conducted with the facility's Director of Nursing (DON) on 2/5/25 at 8:40 AM, the DON stated the only orientation material the facility provided for agency nurses was the "Information Packet for Registry Nurses." She acknowledged the facility did not provide education on glucometer disinfection to agency nurses prior to the nurse working at the facility. The DON stated it was assumed that agency nurses had received training to ensure their overall competency to care for residents prior to being hired and assigned to work in their facility.

A follow-up interview was conducted on 2/7/25 at 8:19 AM with the DON to inquire about the training / orientation provided to newly hired staff

F 726

" Complete blood glucose monitoring procedure as outlined above
" Proper hand hygiene and glove use at specified steps
" Correct glucometer cleaning and disinfection technique
" Appropriate wet contact time monitoring
" Proper barrier use and storage procedures
" Return demonstration required for all steps
" Documentation of competency verification in employee file
" No blood glucose monitoring permitted until competency validated
" The education provided stressed the importance of using individually assigned glucometers for each resident requiring blood glucose monitoring and storing these glucometers in individual, re-sealable plastic bags. The in-service training also included a review of the manufacturer's instructions for the facility's glucometer and disinfectant wipes related to glucometer disinfection, as well as completing a return demonstration of the proper procedures for effective glucometer disinfection.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained
" The Director of Nursing/designee will conduct random audits of five (5) licensed nurses performing blood glucose monitoring three (3) times per week for six (6) consecutive weeks, then monthly for three (3) months to ensure compliance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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F 726

Continued From page 58

nurses. When asked, the DON reported that staff nurses went through an orientation program led by the facility's Staffing Coordinator and Human Resources Manager. She also noted new staff nurses were assigned a mentor to supplement their orientation.

A telephone interview was conducted with the facility's Medical Director on 2/6/25 at 2:27 PM to discuss the concerns related to glucometer disinfection identified during observations conducted at the facility. When asked, the Medical Director reported she had been informed of these concerns. She reported this "sounded like a training issue" and stated, "This is the first time I have heard of this happening." The Medical Director reported she thought glucometer disinfection required better learning or training "for all staff throughout."

The facility's Administrator and DON were informed of the immediate jeopardy (IJ) on 2/5/25 at 2:00 PM.

The facility provided the following plan for IJ removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

On 02/04/2025, an agency nurse (Nurse #1) provided care without receiving proper orientation and competency validation regarding glucometer disinfection procedures. The nurse used a glucometer dedicated to Resident #134 for Resident #107 without proper disinfection between residents. When interviewed, the nurse stated they were unaware of facility policies and

F 726

with glucometer disinfection procedures. Any identified deficiencies will be corrected immediately, and additional education will be provided to the involved staff.
" The Director of Nursing/designee will review agency nurse orientation documentation weekly for six (6) weeks, then monthly for three (3) months.
" Results of these audits will be reviewed and analyzed by the QAPI/QA Committee for trends and additional corrective action.
" This plan of correction will be monitored at the monthly QAPI/QA meeting until such time consistent substantial compliance has been met.
" Completion Date: 3/4/2025 and ongoing

| 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 02/07/2025 |

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| F 726 | Continued From page 59 | F 726 | | |

procedures for glucometer disinfection and did not know which products were approved for disinfection.

All residents requiring blood glucose checks were identified as being at risk. An audit conducted by the Director of Nursing and nursing unit coordinators on 02/04/2025 identified all facility residents requiring blood glucose checks and confirmed the presence of residents with blood borne pathogens, creating risk for cross-contamination.
The following immediate actions were taken:
- At approximately 7:00 AM on 02/04/2025, upon discovery of the incident, Nurse #1 was immediately removed from resident care duties
- The Director of Nursing contacted Nurse #1 by telephone regarding the requirement to complete comprehensive glucometer competency validation before accepting any future assignments at the facility

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete
The following systemic changes have been implemented as of 02/05/2025:
1. Comprehensive Glucometer Training and Competency Program:
All licensed nurses (including facility staff and agency staff) must complete the following training and demonstrate competency before performing blood glucose monitoring:
a. Required Equipment and Supplies:
- Gloves
- Glucometer
- Alcohol pads
- Single-use lancet

| 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 02/07/2025 |

| 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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| F 726 | Continued From page 60<br>- Blood glucose testing strips<br>- Disinfecting wipes<br>- Paper towels or tissues<br>b. Complete Glucometer Procedure and Cleaning Steps:<br>- Obtain needed equipment and supplies<br>- Perform hand hygiene<br>- Explain the procedure to the resident<br>- Provide privacy<br>- Don gloves<br>- Obtain capillary blood glucose sampling<br>- Remove and discard gloves, perform hand hygiene prior to exiting the room<br>- Retrieve (2) disinfectant wipes from container<br>- Using the first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer<br>- After cleaning, disinfect with second wipe, maintaining 3-minute wet contact time. Allow the glucometer to air dry<br>- Discard disinfectant wipes in waste receptacle<br>- Perform hand hygiene<br>- Ensure glucometer is stored in individual plastic bag for each resident to prevent cross contamination<br>- Place clean dry paper towel or tissue under glucometer before placing on resident table or on top of medication cart to prevent contamination<br>2. Competency Validation Process:<br>Direct observation by nurse management of:<br>- Complete blood glucose monitoring procedure as outlined above<br>- Proper hand hygiene and glove use at specified steps<br>- Correct glucometer cleaning and disinfection technique<br>- Appropriate wet contact time monitoring<br>- Proper barrier use and storage procedures<br>- Return demonstration required for all steps | F 726 | | |

| 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 02/07/2025 |

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|---|---|
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| F 726 | Continued From page 61<br>- Documentation of competency verification in employee file<br>- No blood glucose monitoring permitted until competency validated<br>3. Ongoing Monitoring:<br>- The Director of Nursing maintains documentation of all completed competency validations<br>- The staffing coordinator verifies completion of glucometer competency before scheduling<br>Immediate Jeopardy Removal Date: 2/6/2025<br><br>The facility's credible allegation of immediate jeopardy removal was validated on 2/7/25. The validation was evidenced by nurse observations and/or interviews conducted on each hallway with regards to the required infection control practices for the disinfection of glucometers. All nurses who were interviewed reported they had received the required in-service training prior to beginning their shift. The education provided stressed the importance of using individually assigned glucometers for each resident requiring blood glucose monitoring and storing these glucometers in individual, re-sealable plastic bags. The in-service training also included a review of the manufacturer's instructions for the facility's glucometer and disinfectant wipes related to glucometer disinfection, as well as completing a return demonstration of the proper procedures for effective glucometer disinfection. Nurses observed to conduct blood glucose checks and subsequent glucometer disinfection completed the task without difficulty. The nursing practices observed included the proper handling and storage of glucometers to protect the meters from potential cross-contamination via contact with other meters or surfaces. There were no concerns identified during either the interviews or | F 726 | | |

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|---|---|---|---|
| | 345434 | A. BUILDING ______ B. WING ______ | C 02/07/2025 |

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|---|---|
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|---|---|---|---|---|
| F 726 | Continued From page 62 | F 726 | | |

observations.

The credible allegation was validated, and the immediate jeopardy was removed on 2/6/25.

2. An interview was conducted on 2/4/25 at 12:14 PM with Nurse #2. During the interview, the nurse estimated that she had worked at the facility four times in the last three months. On 2/4/25 at 12:35 PM, a follow-up interview was conducted with the nurse. At that time, Nurse #2 was asked if she received orientation upon starting to work at the facility. She stated, "No, I did not." When asked, Nurse #2 reported she did not know how long a glucometer should remain wet (wet contact time) after using a disinfectant wipe to ensure the meter was adequately disinfected.

On 2/4/25, the facility provided a copy of the orientation packet given to agency nurses when they first began working at the facility. A review of the "Information Packet for Registry Nurses" revealed it contained the following topics: Welcome to [Name of Facility]; Important Guidelines (including dress code, personal devices, medication protocol, supplies, and identification); Admission Assessment (indicating the admission documentation required); Nurse Responsibilities in Admission; Daily Responsibilities; and Documentation Expectations.

During an interview conducted with the facility's Director of Nursing (DON) on 2/5/25 at 8:40 AM, the DON stated the only orientation material the facility provided for agency nurses was the "Information Packet for Registry Nurses." She acknowledged the facility did not provide

| 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 02/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 726 | Continued From page 63<br>education on glucometer disinfection to agency nurses prior to the nurse working at the facility. The DON stated it was assumed that agency nurses had received training to ensure their overall competency to care for residents prior to being hired and assigned to work in their facility.<br><br>A follow-up interview was conducted on 2/7/25 at 8:19 AM with the DON to inquire about the training / orientation provided to newly hired staff nurses. When asked, the DON reported that staff nurses went through an orientation program led by the facility's Staffing Coordinator and Human Resources Manager. She also noted new staff nurses were assigned a mentor to supplement their orientation.<br><br>A telephone interview was conducted with the facility's Medical Director on 2/6/25 at 2:27 PM to discuss the concerns related to glucometer disinfection identified during observations conducted at the facility. When asked, the Medical Director reported she had been informed of these concerns. She reported this "sounded like a training issue" and stated, "This is the first time I have heard of this happening." The Medical Director reported she thought glucometer disinfection required better learning or training "for all staff throughout." | F 726 | | |
| F 759 SS=D | Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)<br><br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>This REQUIREMENT is not met as evidenced | F 759 | | 3/4/25 |

| 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 02/07/2025 |

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|---|---|---|---|---|

F 759

Continued From page 64

by:
Based on observations, staff interviews, and record reviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 25 opportunities, resulting in a medication error rate of 8% for 2 of 5 residents (Residents #85 and #8) observed during the medication administration observation.

The findings included:

1. Resident #85 was admitted to the facility on 7/26/24.

On 2/4/25 at 11:26 AM, Nurse #2 was observed as she prepared nine (9) medications for administration to Resident #85. The medications included two tablets of a combination medication with each tablet containing 8.6 milligrams (mg) sennosides (a stimulant laxative) / 50 mg docusate (a stool softener) taken from a stock medication bottle stored on the medication (med) cart. The medication was administered to Resident #85 on 2/4/25 at 11:40 AM.

A review of Resident #85's current physician's orders revealed his medication orders included 8.6 mg sennosides (a stimulant laxative) to be given as two tablets by mouth two times a day for constipation (Start Date 7/26/24). Resident #85 did not have a physician's order for docusate.

An interview was conducted with Nurse #2 on 2/4/24 at 12:35 PM related to the medication administration observed on 2/4/25 at 11:26 AM. During the interview, Resident #85's Medication Administration Record (MAR) was reviewed. At that time, Nurse #2 confirmed his physician's

F 759

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice
" The Director of Nursing assessed Residents #85 and #8 for any adverse effects related to the medication errors and documented the findings in their medical records. The licensed nurses who administered the medications were provided one-on-one education regarding proper medication administration techniques specific to the errors identified.
" Completion Date: 2/24/2025

Address how the facility will identify other residents having the potential to be affected by the same deficient practice
" The Director of Nursing/designee conducted medication pass observations for each resident receiving medications to identify any additional medication errors and provided immediate correction for any issues identified.
" Completion Date: 2/24/2025

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
" All licensed nurses and med aides have competency to administer medications validated by a nurse manager prior to accepting/starting a medication cart assignment.
" The Director of Nursing/designee will provide education to all licensed nursing staff regarding proper medication

| 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 02/07/2025 |

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|---|---|---|---|---|

F 759

Continued From page 65

order was written for 8.6 mg sennosides (not a combination medication including sennosides and docusate). The stock bottle used for the med administration was also pulled from the med cart and the label of this stock bottle reviewed. At that time, Nurse #2 acknowledged each tablet of the medication contained 8.6 mg sennosides with 50 mg docusate. Upon further review of the stock meds available on the medication cart, the nurse identified a bottle containing 8.6 mg sennosides (as the sole active ingredient) was stored on the med cart and available for administration. During the interview, Nurse #2 acknowledged she administered the wrong medication to Resident #85 during the medication observation conducted earlier that morning. The nurse reported she would alert the nurse supervisor to this error.

An interview was conducted on 2/5/25 at 3:43 PM with the facility's Director of Nursing (DON). During the interview, the DON reported she would expect nursing staff to verify the right medication and right dose during the med administration process as part of the "medication rights" (right patient, right drug, right dose, right route, and right time).

2. Resident #8 was admitted to the facility on 2/8/21.

On 2/5/25 at 9:08 AM, Nurse #3 was observed as she prepared thirteen (13) medications for administration to Resident #8. The medications included one tablet of a combination medication containing 600 milligrams (mg) calcium carbonate with 10 micrograms (400 units) of Vitamin D taken from a stock medication bottle stored on the medication (med) cart. A continuous observation was conducted as the medications

F 759

administration techniques, including the six rights of medication administration, proper documentation, and error prevention strategies. Staff will not be allowed to work until they have received the required training, and documentation of attendance will be maintained in employee training records.
" Completion Date: 3/4/2025

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained
" The Director of Nursing/designee will conduct random medication pass observations of five (5) licensed nursing staff weekly for six (6) consecutive weeks, then monthly for three (3) months to ensure the ten rights of medication administration (Right Patient, Right Medication, Right Dose, Right Route, Right Time, Right Documentation, Right to Refuse, Right Assessment, Right Education, and Right Evaluation) are being followed. Any identified deficiencies will be corrected immediately, and additional education will be provided to the involved staff.
" Results of these audits will be reviewed and analyzed by the QAPI/QA Committee for trends and additional corrective action.
" This plan of correction will be monitored at the monthly QAPI/QA meeting until such time consistent substantial compliance has been met.
" Completion Date: 3/4/2025 and ongoing

F 759 Continued From page 66 F 759

were administered to Resident #8.

A review of Resident #8's current physician's orders revealed her medication orders included a combination medication containing 500 mg calcium carbonate with 200 units of Vitamin D to be given as one tablet by mouth two times a day for hypocalcemia (low levels of calcium in the blood) with a start date of 4/1/22. The resident's medication orders also included a current (but separate) order for 2,000 units of Vitamin D to be administered as one tablet by mouth one time a day for supplement (Start Date 2/9/21).

An interview was conducted with Nurse #3 on 2/5/25 at 12:14 PM. During the interview, the discrepancy between the dosage of the calcium / Vitamin D combination medication observed to have been administered to Resident #8 on 2/5/25 at 9:08 AM (versus the dosage ordered by the physician) was discussed. At that time, both the resident's Medication Administration Record (MAR) and label of the stock bottle of the calcium / Vitamin D supplement observed to have been pulled for Resident #8's medication administration were reviewed. During the interview, Nurse #3 insisted she knew Resident #8 was ordered 500 mg calcium with Vitamin D and thought she had pulled the correct medication from the stock bottles. The nurse was informed the label of the stock bottle handed off for review during Resident #8's medication observation indicated the dosage of the tablet administered to the resident was 600 mg calcium / 400 units Vitamin D (not the 500 mg calcium / 200 units of Vitamin D ordered for her).

An interview was conducted on 2/5/25 at 3:43 PM with the facility's Director of Nursing (DON). During the interview, the DON reported she would

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|---|---|---|---|
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|---|---|---|---|---|
| F 759 | Continued From page 67<br>expect nursing staff to verify the right medication and right dose during the med administration process as part of the "medication rights" (right patient, right drug, right dose, right route, and right time). | F 759 | | |
| F 761 SS=E | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to: 1) Discard expired medications on 2 of 5 medication (med) carts observed (Front | F 761 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient | 3/4/25 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|---|---|---|
| F 761 | Continued From page 68<br>200 Hall Med Cart and Back 200 Hall Med Cart) and in 1 of 2 medication storerooms (400 Hall Medication Storeroom); and 2) Date medications as to when they were opened to allow for the determination of its shortened expiration date for meds stored on 2 of 5 med carts (Front 200 Hall Med Cart and Front 400 Hall Med Cart) and in 1 of 2 medication storerooms (400 Hall Medication Storeroom).<br><br>The findings included:<br><br>1. An observation was conducted on 2/3/25 at 1:24 PM of the Front 200 Hall Medication (Med) Cart in the presence of Nurse #4. The observation revealed the following medications were stored on the med cart:<br><br>a. One bubble-pack card containing 29 tablets of 0.125 milligrams (mg) hyoscyamine (a medication that may be used to treat muscle spasms in the bowel or bladder) was stored past its expiration date. The pharmacy labeling on the bubble-pack card indicated this medication was dispensed for Resident #46 on 5/23/23 and had an expiration date of 5/23/24.<br><br>b. One stock bottle of 100 mg docusate (a stool softener) was stored past its expiration date. The stock bottle originally contained 200 softgels (with approximately 180 remaining in the bottle) and was observed to have a manufacturer expiration date of September 2024.<br><br>c. According to the manufacturer, containers of latanoprost eye drops (a medication used to treat glaucoma) may be stored at room temperature up to 77 degrees Fahrenheit (o F) for 6 weeks. | F 761 | practice<br>" The Director of Nursing conducted an immediate removal of all expired medications from the Front 200 Hall Med Cart, Back 200 Hall Med Cart, and 400 Hall Medication Storeroom. The Director of Nursing verified all medications currently in use were within their expiration dates and properly labeled with opening dates where required.<br>" Completion Date: 2/24/2025<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice<br>" The Director of Nursing/designee conducted a comprehensive audit of all medication carts, medication rooms, and medication storage areas throughout the facility to identify and remove any expired medications and to ensure all medications requiring dating upon opening were properly labeled with opening dates.<br>" Completion Date: 2/24/2025<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur<br>" The Unit Manager/designee will incorporate medication storage checks into the clinical rounds checklist; including verification of medication expiration dates and proper labeling of medications with opening dates. These findings will be reviewed during daily clinical meetings to ensure ongoing compliance with medication storage and labeling requirements. | |

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|---|---|---|---|
| | 345434 | A. BUILDING ______ B. WING ______ | C 02/07/2025 |

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|---|---|---|---|---|

F 761 Continued From page 69

One opened bottle of 0.005% latanoprost eye drops dispensed from the pharmacy for Resident #160 on 12/2/24 was stored on the medication cart. The bottle was not dated as to when it had been opened to allow for the determination of its shortened expiration date.

An interview was conducted on 2/3/25 at 1:38 PM with Nurse #4. After examining the labeling on the medications, Nurse #4 agreed the hyoscyamine and docusate medications were expired. She also expressed concern related to not knowing when the latanoprost eye drops dispensed for Resident #160 had been opened. Nurse #4 reported the resident's medications had been recently moved to this med cart, so she would check the resident's previous medication cart to see if there was another bottle of latanoprost dispensed for her on that cart.

2. An observation was conducted on 2/3/25 at 1:39 PM of the Back 200 Hall Medication (Med) Cart in the presence of Nurse #5. The observation revealed the following medications were stored on the med cart:

a. One bubble-pack card containing 3 tablets of 40 milligrams (mg) rosuvastatin (a medication used to treat high levels of lipids and cholesterol in the blood) was stored past its expiration date. The pharmacy labeling on the bubble-pack card indicated this medication was dispensed for Resident #108. The labeling did not contain a legible dispensed date. However, the medication had an expiration date of 11/19/24.

b. Twenty (20) syringes containing 0.5 mg lorazepam (an antianxiety medication and a controlled substance medication) was stored in

F 761

" The Director of Nursing/designee will provide education to all licensed nursing staff and medication aides regarding proper medication storage requirements, including checking expiration dates, dating medications when opened, and proper disposal of expired medications. Staff will not be allowed to work until they have received the required training, and documentation of attendance will be maintained in employee training records.
" Completion Date: 3/4/2025

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained
" The Director of Nursing/designee will conduct random audits of five (5) medication storage areas (including medication carts and medication rooms) three (3) times per week for six (6) consecutive weeks, then monthly for three (3) months to ensure compliance with medication storage and labeling requirements. These audits will verify that no expired medications are present and that all medications are properly labeled. Any identified deficiencies will be corrected immediately, and additional education will be provided to the involved staff.
" Results of these audits will be reviewed and analyzed by the QAPI/QA Committee for trends and additional corrective action.
" This plan of correction will be monitored at the monthly QAPI/QA meeting until such time consistent substantial compliance has been met.

| 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 02/07/2025 |

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| F 761 | Continued From page 70<br>the locked drawer of the medication cart. The medication was labeled by the pharmacy as dispensed for Resident #150 on 12/2/24 with an expiration date of 12/19/24.<br><br>An interview was conducted with Nurse #5 at the time of the med storage observation on 2/3/25 at 1:39 PM. During the interview, the nurse confirmed the rosuvastatin and lorazepam identified on the med cart were expired. Nurse #5 reported she would remove both medications from the med cart and bring them to the Director of Nursing (DON).<br><br>3. According to the manufacturer, in-use prefilled pens of Lantus insulin should be stored at room temperature and used within 28 days.<br><br>An observation was conducted on 2/4/25 at 6:22 AM of the Front 400 Hall Medication (Med) Cart in the presence of Nurse #1. The observation revealed an in-use Lantus insulin pen dispensed for Resident #175 was not labeled as to when it was opened to allow for the determination of its shortened expiration date. Additionally, the label on the insulin pen did not indicate when it was dispensed from the pharmacy.<br><br>At the time of the observation conducted on 2/4/25 at 6:22 AM, Nurse #1 was shown the insulin pen and asked when it had been opened. Nurse #1 stated he did not know and confirmed there was no date written on the pen to indicate when it was opened.<br><br>4. An observation was conducted on 2/4/25 at 6:30 AM of the 400 Hall Medication Storeroom in the presence of Nurse #1 and the facility's Director of Nursing (DON). The observation | F 761 | " Completion Date: 3/4/2025 and ongoing | |

| 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 02/07/2025 |

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|---|---|---|---|---|
| F 761 | Continued From page 71 | F 761 | | |

revealed the following medications were stored in the medication storeroom:

a. The manufacturer's storage instructions for a multi-dose vial of Tuberculin PPD (Purified Protein Derivative) injectable solution (used for skin testing in the diagnosis of tuberculosis) indicated that once opened, the product should be discarded after 30 days.

One (1) opened multi-dose vial of Tuberculin PPD injectable solution was stored in the med room refrigerator. Neither the vial nor the manufacturer box it was stored in were labeled as to when the vial had been opened to allow for the determination of its shortened expiration date.

b. Three (3) unopened stock bottles of 100 micrograms Vitamin B-12 were stored in the medication storeroom. Each bottle contained 100 tablets and was labeled to have a manufacturer expiration date of January 2025.

An interview was conducted with the Director of Nursing (DON) at the time of the med storage observation conducted on 2/4/25 at 6:30 AM. At that time, the DON reported that the Tuberculin PPD injectable solution needed to be discarded, and the stock bottles of Vitamin B-12 also needed to be removed from the medication storeroom due to being past their expiration date.

A follow-up interview was conducted with the DON on 2/7/25 at 8:21 AM. During the interview, the medication storage observations were discussed. The DON reported she had been made aware of the concerns related to expired medications and the failure to date medications as to when they were opened.

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|---|---|---|---|
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|---|---|---|---|---|
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(h)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(h) Medical records.<br>§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted | F 842 | | 3/4/25 |

| 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 02/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 842 | Continued From page 73<br>by and in compliance with 45 CFR 164.512.<br><br>§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(h)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(h)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident and staff interviews, the facility failed to maintain accurate medical records in the areas of medication allergies (Resident #185), failed to document the administration of pain medication (Resident #70), and document discharge to community Against Medical Advice (AMA) (Resident #187) for 3 of 8 residents' records reviewed.<br><br>Findings included: | F 842 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice<br>" The Director of Nursing/designee reviewed and documented Resident #70's pain medication administration record to ensure completeness, and updated Resident #187's medical record to properly document their Against Medical Advice (AMA) discharge to the | |

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|---|---|---|---|
| | 345434 | A. BUILDING ______ B. WING ______ | C 02/07/2025 |

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|---|---|
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|---|---|---|---|---|
| F 842 | Continued From page 74 | F 842 | | |

1. Resident #185 was admitted to the facility on 2/5/24 with the diagnosis of chronic atrial fibrillation (irregular heartbeat).

A review of Resident #185's hospital record dated 2/5/24 documented the resident had a medication allergy to aspirin and Compazine (nausea).

A review of Resident #185's facility electronic medical record documented the resident had no known allergies in the medication allergy tab. The Medication Administration Record dated February 2024 documented no known allergies. The resident was not prescribed aspirin and/or Compazine. The resident was discharged on 2/17/24.

On 2/6/24 at 1:42 pm an interview was conducted with the Director of Nursing (DON). The DON stated the resident's medication allergy(s) were required to be listed in their medical record by the admitting nurse.

2. Resident #70 was admitted to the facility on 5/23/22 with the diagnosis of type 2 diabetes mellitus, stage 4 prostate cancer and Lupus.

The quarterly Minimum Data Set(MDS) dated 1/13/25 revealed Resident #70's cognition was intact.

Resident #70 had orders dated 11/4/24 for Methadone HCL oral tablet 5mg by mouth one time a day for pain at 8:00 AM and 1.5 tablet by mouth at bedtime(10:00PM).

An interview on was conducted on 02/03/25 at 1:52 PM with Resident#70 who stated back in November 2024 he requested pain medication

community. Resident #185 has been discharged from the facility and is no longer a resident.
" Completion Date: 2/24/2025

Address how the facility will identify other residents having the potential to be affected by the same deficient practice
" The Director of Nursing/designee reviewed all residents discharged Against Medical Advice (AMA) within the past 30 days to ensure complete discharge documentation was present in their medical records.
" The Director of Nursing/designee reviewed all new admissions within the past 30 days to verify accurate documentation of medication allergies in all sections of the electronic health record and paper Medication Administration Record.
" The Director of Nursing/designee reviewed the medication administration audit report for the past 30 days to identify any missing documentation of medication administration and updated records to reflect accurate administration times for medications that were administered.
" Completion Date: 2/24/2025

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
" The Unit Manager/designee will incorporate verification of medication allergy documentation, medication administration records completion, and discharge documentation into daily clinical

| 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 02/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 842 | Continued From page 75<br>and was receiving it very late after the scheduled time. Resident #70 stated he did not understand why staff were so late giving him his medication.<br><br>A review of Resident #70's Medication Administration Record for November 2024 revealed there was no documentation the medication was given on 11/4/24 at 10:00 PM. The scheduled 10:00 PM dose was documented as administered on 11/5/24 at 9:59 AM.<br><br>An interview was conducted on 2/5/25 at 4:00 PM in conjunction with a record review with the Director of Nursing. She reviewed the Medication Administration Audit report and confirmed the scheduled dose Methadone of 1.5mg on 11/4/24 at bedtime was not documented until 11/5/24. The Director of Nursing stated she had received reports from residents that Nurse #18 was not giving medication as scheduled, when she counseled the Nurse#18 about medication administration, she would state she had given the medication and documented late. She stated Nurse #18 no longer worked for the facility due to a history of not documenting when medications were given or not documenting at all.<br><br>A telephone interview was conducted on 2/6/25 at 8:40 AM, the assigned Nurse#18 who stated if the medication was scheduled for 10:00 PM she was pretty sure she had given the medication and may have charted late.<br><br>A telephone interview was conducted on 2/7/25 at 10:06 AM, with the Nurse Practitioner #2 who stated Resident #40 had reported pain medications were administered late. The Nurse Practitioner#2 further stated she reviewed the record and there have been times Resident #70 | F 842 | rounds, with findings reviewed during daily clinical meetings to ensure ongoing accuracy and completeness of medical records.<br>" The Director of Nursing/designee will provide education to all licensed nursing staff, social services staff, and medical records staff regarding proper documentation of medication allergies, medication administration, and discharge documentation including Against Medical Advice (AMA) procedures. Any staff who do not receive this education by the completion date will not be allowed to work until they have completed this required training. New hires will receive this education during orientation before providing direct resident care. Documentation of attendance will be maintained in employee training records.<br>" Completion Date: 3/4/2025<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained<br>" The Director of Nursing/designee will conduct audits three (3) times per week for six (6) consecutive weeks, then monthly for three (3) months to ensure compliance with documentation requirements. These audits will include all Against Medical Advice (AMA) discharges, five (5) new admissions per week for allergy documentation verification, and resident interviews to confirm medication administration against documentation records. Any identified deficiencies will be corrected immediately, and additional education will be provided to the involved | |

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|---|---|---|---|
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|---|---|---|---|---|

F 842

Continued From page 76

received the pain medication much later than scheduled and there would be late documentation.

3. Resident #187 was admitted to the facility on 10/14/24.

Review of the discharge return not anticipated Minimum Data set Assessment dated 10/15/24 revealed the resident was discharged home/ community.

Review of the medical records revealed no nursing notes or AMA form related to Resident's #187 discharge.

During an interview on 2/5/25 at 11:07 AM, Unit Manager #4 stated the resident had brief stay at the facility. The resident was admitted to the facility on 10/14/25 at around 6:00 PM and left the facility Against Medical Advice (AMA) on 10/15/24. The resident's family were in the facility on 10/15/24 and hurriedly took Resident #187 home. The Unit Manager #4 stated that any resident who wants to be discharged on AMA, the resident/resident representative had to be signed the AMA form. Unit Manager #4 indicated there was no document in the chart that indicated the resident left the facility AMA. The Unit Manager further indicated she was unsure why there was no documentation about the resident leaving the facility AMA.

The nurse assigned to Resident #187 on 10/15/24 was unavailable to be interviewed.

During an interview on 2/7/25 at 1:43 PM, the Administrator indicated if any resident was leaving the facility Against Medical Advice (AMA),

F 842

staff.

" Results of these audits will be reviewed and analyzed by the QAPI/QA Committee for trends and additional corrective action.

" This plan of correction will be monitored at the monthly QAPI/QA meeting until such time consistent substantial compliance has been met.

" Completion Date: 3/4/2025 and ongoing

| 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 02/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| --- | --- | --- | --- | --- |
| F 842 | Continued From page 77 then the AMA form should be signed by the resident and/or resident's family. If the family refuses to sign it, then 2 staff members had to sign it as witnesses. The resident's medical records should be uploaded with the AMA form and a note indicating the circumstances of the discharge. The Administrator indicated Resident #187 was a PACE ( Program of All-Inclusive Care for the Elderly) resident and was closely followed by PACE for all his medical care and other needs. | F 842 | | |
| F 880 SS=J | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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 §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, | F 880 | | 3/4/25 |

| 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 02/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 880 | Continued From page 78 | F 880 | | |

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.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|---|---|---|

F 880

Continued From page 79

This REQUIREMENT is not met as evidenced by:

Based on record reviews, observations, and interviews with staff and Medical Director, the facility staff failed to disinfect a shared blood glucose meter (glucometer) between residents for 1 of 3 residents (Resident #107) observed to have her blood glucose (sugar) level checked. This occurred while there were 18 residents identified with a known bloodborne pathogen in the facility. Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-registered disinfectant in accordance with the manufacturer of the glucometer potentially exposes residents to the spread of bloodborne infections. Care must also be taken by personnel handling and storing glucometers to protect the glucometers against cross-contamination via contact with other meters or equipment. Also, the facility failed to disinfect individually assigned glucometers stored outside of the residents' rooms in accordance with the instructions provided by the manufacturer of the disinfectant wipes for 2 of 3 residents (Residents #66 and #93) observed to have their blood glucose levels checked.

Immediate jeopardy began on 2/4/25 when Nurse #1 was observed to perform blood glucose testing for Resident #107 using a glucometer dedicated to Resident #134 without disinfecting the shared glucometer between residents.
Immediate jeopardy was removed on 2/6/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of

F 880

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice
" At approximately 7:00 AM on 02/04/2025, upon discovery of the incident, the Director of Nursing and the Unit Coordinator cleaned and disinfected the glucometer per manufacturer guidelines and professional standards.
" On 02/04/2025, Resident #107 was assigned a new individual glucometer by the Unit Coordinator, labeled with the resident's name using a label maker and stored in an individual re-sealable plastic bag in the medication cart.
" Resident #107's medical provider was notified of this occurrence by the Director of Nursing with no additional instructions provided.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice
" All residents requiring blood glucose checks are at risk of being affected by this practice.
" An audit conducted by the Director of Nursing and nursing unit coordinators on 02/04/2025 identified all facility residents requiring blood glucose checks.
" All residents were confirmed to have an individual glucometer assigned.
" Each glucometer is labeled with the resident's name using a label maker and stored in individual re-sealable plastic bags in the medication cart.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|---|---|---|
| F 880 | Continued From page 80 | F 880 | | |

compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not immediate jeopardy) for finding #2 and for the facility to complete agency and employee staff training with monitoring to ensure appropriate interventions are put into place.

The findings included:

The manufacturer instructions for cleaning and disinfecting the (Brand Name) glucometer used at the facility were summarized in a Technical Brief (Revised 9/24). The Technical Brief read in part, "To minimize the risk of transmitting bloodborne pathogens, the cleaning and disinfecting procedures should be performed as recommended in the instructions below. The (Brand Name) meter may only be used for testing multiple patients when standard precautions and the manufacturer's disinfecting procedures are followed. The meter should be cleaned and disinfected after use on each patient. The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfecting procedure. The disinfecting procedure is needed to prevent the transmission of bloodborne pathogens ...Clean and disinfect the meter following step-by-step instructions in the Quality Assurance (QA) / Quality Control (QC) Reference Manual."

Cleaning and Disinfecting Procedures specified in the glucometer's QA/QC Reference Manual (Revised 10/24) included, in part:
--Cleaning:
Step 1 (of 7): Wear appropriate protective gear such as disposable gloves.
Step 3 (of 7): Wipe surface of the meter to clean blood and other body fluids ...

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
" Staff Education and Competency Validation:
" The agency nurse involved was contacted by telephone by the Director of Nursing to provide education regarding proper glucometer disinfection protocols. The Director left a voicemail, and the nurse will not be allowed to accept a resident care assignment at facility prior to education and blood glucose competency being validated in person.
" All licensed nurses were educated by the Director of Nursing and nursing unit coordinators regarding:
" The importance of using appropriate EPA registered disinfectant wipes
" Following manufacturer's instructions for cleaning and disinfection
" Requirements for stocking medication carts with EPA-registered disinfectant wipes
" Blood glucose monitoring is performed only by licensed nurses at the facility
" All licensed nurses' competency to check blood glucose, including proper disinfection, was validated through direct observation by nurse management. This validation included observation of:
" Proper glucometer disinfection technique
" Correct storage of glucometers in labeled individual re-sealable plastic bags
" Complete blood glucose monitoring

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|

F 880

Continued From page 81

Step 4 (of 7): If blood is visible on the meter, it should be cleaned prior to each disinfection step.
--Disinfecting:
Step 5 (of 7): Pull out 1 new towelette and wipe the entire surface of the meter horizontally and vertically to remove bloodborne pathogens. Carefully wipe around the test strip port by inverting the meter so that the test strip port is facing down.
Step 6 (of 7): Treated surface must remain wet for recommended contact time. Please refer to wipe manufacturer's instructions.

The manufacturer's Technical Brief for the glucometer listed the disinfectant wipes used at the facility as one of the EPA-registered wipes recommended to clean and disinfect the (Brand Name) glucometer. The instructions on the label of the disinfectant wipes read in part: "To clean and disinfect and deodorize hard, nonporous surfaces: Wipe surface to be disinfected. Use enough wipes to treated surface to remain visibly wet to the contact time listed. Let Dry." Special instructions for cleaning and decontamination against human immunodeficiency virus (HIV), hepatitis B and hepatitis C indicated, "Allow surfaces to remain wet for one minute, let air dry. For all other organisms, see directions for contact time." Mycobacterium bovis (an organism that can cause tuberculosis) was killed in 2 minutes. The instructions indicated enough wipes should be used for the treated surface to remain visibly wet for 3 minutes to kill Clostridium difficile spores.

1. A medication administration observation was initiated on 2/4/25 at 5:39 AM with Nurse #1. Nurse #1 identified himself as an agency (temporary staff) nurse. Upon approaching the

F 880

procedure
" Newly hired, contract, agency, as-needed staff, and staff returning from leave will be educated and have their competency validated through direct observation prior to accepting any resident assignment.
" The Director of Nursing is responsible for tracking education completion and competency validation.
" Process Changes:
" Visual reminders have been placed on all medication carts outlining the complete glucometer procedure:
" Obtain needed equipment and supplies:
" Gloves
" Glucometer
" Alcohol pads
" Single-use lancet
" Blood glucose testing strips
" Disinfecting wipes
" Perform hand hygiene
" Explain procedure to resident
" Provide privacy
" Don gloves
" Obtain blood glucose sampling
" Remove and discard gloves, perform hand hygiene
" Retrieve (2) disinfectant wipes
" Clean with first wipe to remove soil/blood
" Disinfect with second wipe, maintaining 3 minute wet contact time
" Allow to air dry
" Discard wipes
" Perform hand hygiene
" Completion Date: 2/5/2025

| 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 02/07/2025 |

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|---|---|---|---|---|

F 880 Continued From page 82

medication (med) cart, a glucometer was observed to be placed directly on top of the med cart. Nurse #1 reported he needed to do a blood glucose check for Resident #107. Nurse #1 was observed as he collected supplies (a test strip, lancet and alcohol wipe), donned gloves, picked up the glucometer stored on top of the medication cart, and entered Resident #107's room to conduct the blood glucose check. Nurse #1 inserted a strip into the glucometer and used a lancet to puncture the resident's finger. As he held the glucometer (with the strip inserted) at an angle and applied a drop of blood to the strip, the glucometer was observed to have lettering on the side of the meter. After the blood glucose check was completed, Nurse #1 returned to the med cart and placed the glucometer back on top of the medication cart. The side of the glucometer was observed to be labeled with the name of Resident #134. Nurse #1 removed his gloves, opened a drawer of the med cart, and placed this glucometer in the drawer directly in contact with other glucometers which were each stored inside an individual, resealable bag. As the nurse did so, an individually assigned and labeled glucometer for Resident #107's (in a clear, plastic resealable bag) was observed to be stored in the same drawer. At that time, Resident #107's glucometer was pointed out to the nurse. When asked why Resident #107's assigned glucometer was not used for her blood glucose check, Nurse #1 stated, "[I] grabbed the wrong one by mistake."

The interview with Nurse #1 continued on 2/4/25 at 5:46 AM. During the interview, the nurse was informed that the glucometer (labeled for Resident #134) used to check Resident #107's blood glucose was not observed to be disinfected either before or after it was used for her. When

F 880

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained

" The Director of Nursing/designee will conduct random audits of five (5) blood glucose monitoring procedures weekly for six (6) consecutive weeks, then monthly for three (3) months to ensure proper glucometer disinfection techniques are followed, including: use of individually assigned glucometers, proper disinfection with EPA-registered disinfectant wipes, maintaining the required 3-minute wet contact time, and proper storage in individual resealable bags. Any identified deficiencies will be corrected immediately, and additional education will be provided to the involved staff.

" Results of these audits will be reviewed and analyzed by the QAPI/QA Committee for trends and additional corrective action.

" This plan of correction will be monitored at the monthly QAPI/QA meeting until such time consistent substantial compliance has been met.

" Completion Date: 3/4/2025 and ongoing

| 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 02/07/2025 |

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|---|---|---|---|---|
| F 880 | Continued From page 83 | F 880 | | |

asked if this was correct, the nurse stated, "Correct." When asked if it would be correct to say he did not disinfect this glucometer at any point in time, he responded, "yes." The nurse was then asked when glucometers should be disinfected. Nurse #1 stated, "I don't know the routine here." The nurse further explained, "I don't know the protocol [at the facility]." Nurse #1 reported he thought that most places where he worked would have the glucometers cleaned only once at the start of the first nursing shift. Upon further inquiry, the nurse confirmed he didn't disinfect any glucometers on his current night shift while working from 7:00 PM - 7:00 AM. He reported Resident #107 was the only resident whose blood glucose was checked during his shift.

On 2/4/25 at 6:17 AM, a follow-up observation and interview were conducted with Nurse #1. When asked if there were disinfectant wipes stored on the medication cart, Nurse #1 was observed as he pulled each drawer of the med cart open to look. There were no disinfectant wipes stored on the med cart. Nurse #1 stated there should be "sanitation wipes" in a container on the med cart. However, he added that if these wipes were not available on his med cart, he could always use alcohol wipes kept in individual packets on the med cart. The nurse held up two packets of alcohol wipes (taken from the medication cart drawer) to show what he could alternatively use for cleaning/disinfection of the glucometers (alcohol is not an EPA-registered disinfectant approved for glucometer disinfection). When asked to confirm whether he had conducted any other blood glucose checks during his shift, he stated, "That was the only blood glucose I had to do."

| 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 02/07/2025 |

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

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|---|---|---|---|---|
| F 880 | Continued From page 84 | F 880 | | |

An interview was conducted on 2/4/25 at 6:28 AM with the facility's Director of Nursing (DON) as she was standing nearby in the hallway assigned to Nurse #1. When the DON was informed there were no disinfectant wipes on Nurse #1's medication cart, she provided a container of the facility's EPA-registered disinfectant wipes to enable a review of the manufacturer labeling. The DON reported she would expect these wipes to be used for glucometer disinfection with a wet contact time of three (3) minutes, as the product labeling indicated.

On 2/4/25 at 1:30 PM, the facility's DON provided a copy of the facility's (Brand Name) glucometer instructions printed on page 47 of its User Instruction Manual. At that time, an interview conducted with the DON revealed the facility did not have a policy/procedure specifically related to glucometer disinfection. The DON reported the facility used the glucometer instructions which read:
"Cleaning and Disinfecting Guidelines:
Healthcare professionals should wear gloves when cleaning the [Brand Name] meter. Wash hands after taking off gloves. Contact with blood presents a potential infection risk. We suggest cleaning and disinfecting the meter between patient use.
--Cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant detergent or germicide wipe.
--To use a wipe, remove from container and follow product label instructions to disinfect the meter. Take extreme care not to get liquid in the test strip and key code ports of the meter.
--Many wipes act as both a cleaner and disinfectant, though if blood is visibly present 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 02/07/2025 |

| 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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|---|---|---|---|---|
| F 880 | | F 880 | | |

Continued From page 85
the meter, two wipes must be used; use one wipe to clean and a second wipe to disinfect."

An interview was conducted on 2/7/25 at 8:08 AM with the facility's Infection Preventionist. During the interview, the Infection Preventionist was asked what her thoughts were with regards to the concerns identified with the glucometer's disinfection observed on 2/4/25. She stated, "It's unfortunate."

A telephone interview was conducted with the facility's Medical Director on 2/6/25 at 2:27 PM to discuss the concerns related to glucometer disinfection identified during observations conducted at the facility. When asked, the Medical Director reported she had been informed of these concerns. She stated, "This is the first time I have heard of this happening." The Medical Director reported she thought glucometer disinfection required better learning or training "for all staff throughout."

Upon request, the facility provided a Diagnosis Report for its current residents (dated 2/4/25 at 3:39 PM). The Diagnosis Report indicated 18 residents were identified as having at least one bloodborne pathogen, which included hepatitis B, hepatitis C, and HIV.

The facility's Administrator and DON were informed of the immediate jeopardy (IJ) on 2/4/25 at 3:00 PM.

The facility provided the following plan for IJ removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as

| 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 02/07/2025 |

| 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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|---|---|---|---|---|
| F 880 | | F 880 | | |

Continued From page 86
a result of the noncompliance

On 02/04/2025, an agency nurse used a glucometer (blood glucose meter) dedicated to Resident #134 for Resident #107 without disinfecting the shared glucometer between residents. This occurred for 1 of 3 residents who were observed to have their blood glucose checked (Resident #107). At the time of the incident, Resident #107 had an assigned glucometer that was properly labeled with a label maker and stored in the medication cart, but the agency nurse incorrectly used another resident's glucometer instead.

All residents requiring blood glucose checks are at risk of being affected by this practice. An audit conducted by the Director of Nursing and nursing unit coordinators on 02/04/2025 identified all facility residents requiring blood glucose checks. All residents were confirmed to have an individual glucometer assigned. Each glucometer is labeled with the resident's name using a label maker and stored in individual re-sealable plastic bags in the medication cart.

The following immediate actions were taken for affected residents:

- At approximately 7:00 AM on 02/04/2025, upon discovery of the incident, the Director of Nursing and the Unit Coordinator cleaned and disinfected the glucometer per manufacturer guidelines and professional standards
- On 02/04/2025, Resident #107 was assigned a new individual glucometer by the Unit Coordinator, labeled with the resident's name using a label maker and stored in an individual re-sealable plastic bag in the medication cart

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|---|---|---|
| F 880 | Continued From page 87 | F 880 | | |

- Resident #107's medical provider was notified of this occurrence by the Director of Nursing with no additional instructions provided

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

The following systemic changes have been implemented as of 02/04/2025:

1. Staff Education and Competency Validation:

- The agency nurse involved was contacted by telephone by the Director of Nursing to provide education regarding proper glucometer disinfection protocols. The Director left a voicemail, and the nurse will not be allowed to accept a resident care assignment at facility prior to education and blood glucose competency being validated in person
- All licensed nurses were educated by the Director of Nursing and nursing unit coordinators regarding:
- The importance of using appropriate EPA-registered disinfectant wipes
- Following manufacturer's instructions for cleaning and disinfection
- Requirements for stocking medication carts with EPA-registered disinfectant wipes
- Blood glucose monitoring is performed only by licensed nurses at the facility
- All licensed nurses' competency to check blood glucose, including proper disinfection, was validated through direct observation by nurse management. This validation included observation of:
- Proper glucometer disinfection technique

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CARVER LIVING CENTER | 303 EAST CARVER STREET DURHAM, NC 27704 |

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| F 880 | Continued From page 88<br>- Correct storage of glucometers in labeled individual re-sealable plastic bags<br>- Complete blood glucose monitoring procedure<br>- Newly hired, contract, agency, as-needed staff, and staff returning from leave will be educated and have their competency validated through direct observation prior to accepting any resident assignment<br>- The Director of Nursing is responsible for tracking education completion and competency validation<br><br>2. Process Changes:<br><br>- Visual reminders have been placed on all medication carts outlining the complete glucometer procedure:<br>1. Obtain needed equipment and supplies:<br>- Gloves<br>- Glucometer<br>- Alcohol pads<br>- Single-use lancet<br>- Blood glucose testing strips<br>- Disinfecting wipes<br>2. Perform hand hygiene<br>3. Explain procedure to resident<br>4. Provide privacy<br>5. Don gloves<br>6. Obtain blood glucose sampling<br>7. Remove and discard gloves, perform hand hygiene<br>8. Retrieve (2) disinfectant wipes<br>9. Clean with first wipe to remove soil/blood<br>10. Disinfect with second wipe, maintaining 3-minute wet contact time<br>11. Allow to air dry<br>12. Discard wipes<br>13. Perform hand hygiene | F 880 | | |

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|---|---|---|---|---|
| F 880 | Continued From page 89 | F 880 | | |

This infection control breach was reported to the local health department on 2/5/2025, and they provided no further recommendations.
Immediate Jeopardy Removal Date: 2/6/2025

The facility's credible allegation of immediate jeopardy removal was validated on 2/7/25. The validation was evidenced by nurse observations and/or interviews conducted on each hallway with regards to the required infection control practices for the disinfection of glucometers. All nurses who were interviewed reported they had received the required in-service training prior to beginning their shift. The education provided stressed the importance of using individually assigned glucometers for each resident requiring blood glucose monitoring and storing these glucometers in individual, re-sealable plastic bags. The in-service training also included a review of the manufacturer's instructions for the facility's glucometer and disinfectant wipes related to glucometer disinfection, as well as completing a return demonstration of the proper procedures for effective glucometer disinfection. Nurses observed to conduct blood glucose checks and subsequent glucometer disinfection completed the task without difficulty. The nursing practices observed included the proper handling and storage of glucometers to protect the meters from potential cross-contamination via contact with other meters or surfaces. There were no concerns identified during either the interviews or observations.

The credible allegation was validated, and the immediate jeopardy was removed on 2/6/25.

2. An observation of blood glucose checks and medication administration was initiated on 2/4/25

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| F 880 | Continued From page 90<br>at 12:04 PM with Nurse #2. Nurse #2 identified herself as an agency (temporary staff) nurse. As the nurse prepared to conduct a blood glucose check for Resident #66, she removed his individually assigned (and labeled) glucometer from the medication (med) cart drawer. The glucometer labeled for Resident #66 was observed to have been stored in the med cart drawer directly in contact with six (6) other glucometers which were stored in individual, resealable bags. The glucometer for Resident #66 was not stored in an individual, resealable bag. Nurse #2 was observed as she placed the glucometer directly on top of the med cart and collected supplies for the blood glucose check (a test strip, lancet and alcohol wipe) and placed these supplies in a clean plastic cup. The nurse removed a container containing (Brand Name) disinfectant wipes from the bottom drawer of the medication cart and placed it on top of the cart. She did not use any of the disinfectant wipes at that time. Nurse #2 was observed as she picked up the cup (containing the supplies) and glucometer and entered Resident #66's room to conduct a blood glucose check. Upon entering the resident's room, Nurse #2 placed the cup and glucometer on Resident #66's dresser while she used hand sanitizer and donned gloves. The nurse checked Resident #66's blood glucose. On 2/4/25 as 12:12 PM, Nurse #2 returned to the med cart. At that time, she disposed of the used supplies, placed the glucometer directly on the pullout tray of the med cart, and removed her gloves. The nurse performed hand hygiene with hand sanitizer and donned clean gloves. Nurse #2 then picked up the glucometer and used one disinfectant wipe to wipe the meter for 15 seconds. Afterwards, she placed the glucometer back on top of the pullout tray of the med cart, | F 880 | | |

F 880 Continued From page 91 F 880

then into the drawer of the medication cart with the other glucometers. She did not place Resident #66's meter in an individual, resealable bag.

The observation of Nurse #2 continued on 2/4/25 at 12:15 PM as the nurse prepared to check Resident #93's blood glucose. The nurse was observed as she pulled Resident #93's individually assigned (and labeled) glucometer from the medication (med) cart drawer. His glucometer was observed to be stored in an individual, resealable bag while in the drawer. Nurse #2 placed the glucometer (in the bag) on top of the med cart and began to collect the supplies needed for Resident #93's blood glucose check. The nurse reported this resident also needed to receive 3 units of Novolin R (regular) insulin. However, she was unable to find an insulin syringe on the med cart. On 2/4/25 at 12:18 PM, the nurse picked up the glucometer (still in the bag) and supplies and left the med cart to retrieve an insulin syringe. She returned to the med cart on 2/4/25 as 12:23 PM. Upon her return, Nurse #2 placed the glucometer (stored in the bag) and supplies on the top of the med cart. After all of the supplies were collected, Nurse #2 performed hand hygiene and donned a gown and gloves prior to entering the resident's room. Resident #93's room was currently on Enhanced Barrier Precautions (EBP). EBP is an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. On 2/4/25 at 12:27 PM, Nurse #2 entered Resident #93's room, removed his glucometer from its bag and placed the meter on a bedside tray table. After checking the resident's blood glucose level, the glucometer was again placed on the tray table while the

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|---|---|---|---|---|
| F 880 | Continued From page 92 | F 880 | | |

nurse administered the resident's insulin. On 2/4/25 at 12:32 PM, Nurse #2 picked up the glucometer and used supplies and returned to the medication cart. She discarded the used supplies and placed the meter directly on the pullout tray of the med cart. The nurse removed her gloves, performed hand hygiene, and donned clean gloves. She then picked up the glucometer and used one disinfectant wipe to wipe the surface of the glucometer for 20 seconds. The meter was placed directly on top of the med cart as Nurse #2 removed her gloves, put the glucometer back into its individual resealable bag, and returned it to the med cart drawer.

An interview was conducted on 2/4/25 at 12:35 PM with Nurse #2. During the interview, the nurse was asked what the required wet contact time was for the disinfectant wipe to be effective in disinfecting the glucometer. Nurse #2 responded by stating she did not know. When asked, the nurse acknowledged Resident #93's glucometer was not visibly wet when it was put away. Additionally, concern related to the potential for the cross-contamination of both Resident #66's and Resident #93's glucometers was discussed.

During an interview conducted on 2/4/25 at 6:28 AM, the facility's Director of Nursing (DON) reported she would expect the facility's EPA-registered wipes to be used for glucometer disinfection with a wet contact time of three (3) minutes, as the product labeling indicated. On 2/4/25 at 1:30 PM, the facility's DON provided a copy of the facility's (Brand Name) glucometer instructions printed on page 47 of its User Instruction Manual. At that time, an interview conducted with the DON revealed the facility did

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|---|---|---|---|---|
| F 880 | Continued From page 93 | F 880 | | |

not have a policy/procedure specifically related to glucometer disinfection. The DON reported the facility used the glucometer instructions which read:
"Cleaning and Disinfecting Guidelines:
Healthcare professionals should wear gloves when cleaning the [Brand Name] meter. Wash hands after taking off gloves. Contact with blood presents a potential infection risk. We suggest cleaning and disinfecting the meter between patient use.
--Cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant detergent or germicide wipe.
--To use a wipe, remove from container and follow product label instructions to disinfect the meter. Take extreme care not to get liquid in the test strip and key code ports of the meter.
--Many wipes act as both a cleaner and disinfectant, though if blood is visibly present on the meter, two wipes must be used; use one wipe to clean and a second wipe to disinfect."

Upon request, the facility provided a Diagnosis Report for its current residents (dated 2/4/25 at 3:39 PM). The Diagnosis Report indicated 18 residents were identified as having at least one bloodborne pathogen, which included hepatitis B, hepatitis C, and human immunodeficiency virus (HIV).

A follow-up interview was conducted on 2/5/25 at 8:40 AM with the facility's DON. During this interview, the DON reported it was assumed that agency nurses had received training to ensure their overall competency to care for residents prior to being hired and assigned to work in their facility.

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| F 880 | Continued From page 94<br>An interview was conducted on 2/7/25 at 8:08 AM with the facility's Infection Preventionist (IP). During the interview, the IP was asked what her thoughts were with regards to the concerns identified with the glucometers' disinfection observed on 2/4/25. She stated, "It's unfortunate." She added that the facility initiated education and training "then and there" immediately after the concerns were brought to the facility's attention on 2/4/25.<br><br>A telephone interview was conducted with the facility's Medical Director on 2/6/25 at 2:27 PM to discuss the concerns related to glucometer disinfection identified during observations conducted at the facility. When asked, the Medical Director reported she had been informed of these concerns. She stated, "This is the first time I have heard of this happening." The Medical Director reported she thought glucometer disinfection required better learning or training "for all staff throughout." | F 880 | | |