

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345434	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Carver Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 303 East Carver Street Durham, NC 27704	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32394 Based on staff and Registered Dietitian (RD) interviews and record reviews, the facility failed to accurately complete a Minimum Data Set (MDS) assessment to indicate a resident's weight was not obtained during the previous 30-day period for 1 of 2 residents (Resident #6) reviewed who experienced a significant weight loss. The findings included: Resident #6 was admitted to the facility on [DATE]. His cumulative diagnoses included lymphedema (swelling due to build-up of lymph fluid in the body), chronic non-pressure ulcers of the leg, depression, and a history of hypotension (low blood pressure). Review of the resident's electronic medical record (EMR) revealed he weighed 179.7 pounds (#) on 1/5/24. There was no documented evidence that the facility obtained Resident #6's weight between 1/5/24 and 3/18/24. Resident #6's quarterly MDS assessment dated [DATE] reported the resident weighed 180 #. The weight used for this MDS was based on the resident's last recorded weight dated 1/5/24. His 1/5/24 weight was obtained 73 days prior to the MDS's Assessment Reference Date (ARD). An interview was conducted on 5/1/24 at 9:45 AM with the facility's Certified Dietary Manager (CDM). During the interview, the CDM confirmed he completed the Nutrition Section of Resident #6's quarterly MDS dated [DATE]. The CDM reported he used Resident #6's 1/5/24 weight to complete the 3/18/24 MDS because it was his most recent weight. The CDM further explained, We usually use the last available weight. A telephone interview was conducted with the facility's consultant Registered Dietitian (RD) on 5/1/24 at 9:58 AM. During the interview, the RD was asked what weight should be reported in the Nutrition Section of a resident's MDS assessment. The RD stated the Resident Assessment Instrument (instructions for completing an MDS assessment) indicated the weight reported on an MDS should be the most recent measure obtained in the last 30 days. (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 5/1/24 at 10:55 AM with the facility's two MDS Coordinators (MDS Nurse #1 and MDS Nurse #2) and the Regional Director of Clinical Reimbursement. During the interview, the Regional Director of Clinical Reimbursement reviewed Resident #6's quarterly MDS dated [DATE]. When asked, the Regional Director of Clinical Reimbursement reported the facility would typically use the most recent weight closest to 30 days of the MDS's Assessment Reference Date. She confirmed the weight used to complete the Nutrition Section of Resident #6's 3/18/24 MDS was based on his 1/5/24 weight. An interview was conducted on 5/1/24 at 11:18 AM with the facility's Regional Director of Operations. During the interview, concern was shared with her regarding the use of a 1/5/24 weight to complete the Nutrition Section of Resident #6's quarterly MDS dated [DATE]. The Regional Director of Operations stated it was preferable to obtain a more recent weight for a resident within 30 days of the MDS date, if possible. If that was not possible, a dash (-) should have been placed in the blank intended for a weight obtained within 30 days of the MDS assessment.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32394 Based on staff, Registered Dietitian (RD), and Nurse Practitioner (NP) interviews and facility and hospital record reviews, the facility failed to obtain and monitor a resident's monthly weight in February 2024 to identify when a resident's weight loss began and allow for the early assessment and initiation of nutritional interventions. This occurred for 1 of 2 residents (Resident #6) reviewed with a significant weight loss. The findings included: Resident #6 was admitted to the facility on [DATE]. His cumulative diagnoses included lymphedema (swelling due to build-up of lymph fluid in the body), chronic non-pressure ulcers of the leg, depression, and a history of hypotension (low blood pressure). The resident's current plan of care included the following areas of focus, in part: --Resident #6 was at a nutritional risk related to his history of marginal intake with a potential for weight loss, elevated BMI, diagnoses, and increased nutritional needs for wound healing (Revised on: 9/21/23). The planned interventions included: monitor/record/report to his provider signs/symptoms of malnutrition such as emaciation (abnormal thinness), muscle wasting, and significant weight loss such as a loss of 3 pounds in 1 week, more than 5 percent (%) of his weight in 1 month, more than 7.5% in 3 months, or more than 10% in 6 months. Resident #6's EMR documented the following: --On 12/13/23, his weight was 180.2# (obtained via a total mechanical lift scale) and on 12/14/23, the resident's weight was documented as 176.4# (also obtained via a total mechanical lift scale). --On 1/3/24, the resident's laboratory results included an albumin level of 2.9 g/dL (low). --On 1/5/24, Resident #6's monthly weight was documented to be 179.7#. No additional weights were recorded for this resident during the remainder of January. A review of the resident's Meal Intake Record from January 2024 was conducted. The record included documentation of 90 meals during the month of January with the following results: --4% of the meals were refused; --10% of the meals were reported to have 0 - 25% of the meal eaten; --21% of the meals were reported to have 26 - 50% of the meal eaten; --30% of the meals were reported to have 51 - 75% of the meal eaten; --34% of the meals were reported to have 76 - 100% of the meal eaten. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Documentation on Resident #6's January 2024 Medication Administration Record (MAR) revealed he refused the liquid protein supplement one time during the month. A review of Resident #6's February 2024 Meal Intake Record was conducted. The record included documentation of 61 meals during the month of February with the following results: --3% of the meals were refused; --7% of the meals were reported to have 0 - 25% of the meal eaten; --30% of the meals were reported to have 26 - 50% of the meal eaten; --25% of the meals were reported to have 51 - 75% of the meal eaten; --36% of the meals were reported to have 76 - 100% of the meal eaten. Documentation on Resident #6's February 2024 MAR revealed he refused the liquid protein supplement four (4) times during the month. There was no documented evidence that the facility obtained Resident #6's weight during the month of February 2024. Review of the resident's EMR revealed Nurse Practitioner #1 (NP #1) saw Resident #6 for follow-up on 3/18/24. A progress note dated 3/18/24 reported the resident was seen due to staff concerns regarding the resident's decreased appetite and depressed mood. The NP #1 documented he was also being followed by psychiatric services. NP #1's assessment and plan indicated the dose of his antidepressant medication (duloxetine) would be increased from 40 mg to 60 mg daily. The progress note from NP #1's visit reported the resident's weight was 179.7# (his last recorded weight from 1/5/24). Resident #6's most recent Minimum Data Set (MDS) was a quarterly assessment dated [DATE]. The quarterly MDS revealed the resident had intact cognition and did not have any behaviors or rejection of care. He required substantial/maximum assistance for eating. The Nutrition Section of the MDS assessment reported Resident #6 weighed 180# (his last recorded weight from 1/5/24). On 3/19/24, NP #1 wrote a progress note to indicate Resident #6 was again seen regarding his refusal of medications. The resident's medications were reviewed with few changes on meds made due to pt [patient] request and education was provided to him. The discontinued medications included 20 mg furosemide (a diuretic) scheduled to be given to the resident once daily for bilateral leg edema. On 3/22/24, NP #1 wrote a progress note to indicate Resident #6 was again seen upon his family's request. Staff reported the resident was not eating or drinking well. A notation made in NP #1's progress note dated 3/22/24 described the resident's lips as dry and looks dehydrated. At that time, Resident #6 was reported to have declined any lab work being done or being sent out to the hospital for further evaluation. The resident's weight was noted in the NP's progress note as 179.7# (his last recorded weight from 1/5/24). (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/25/24, Resident #6 was weighed, and his weight was recorded in the EMR to be 152.9# (obtained via a total mechanical lift scale). The 3/25/24 weight was indicative of a significant weight loss (26.8#) of 14.9% in the last 80 days compared to his last recorded weight of 179.7# on 1/5/24. His current weight loss also represented a significant weight loss of 15.5% in the past 6 months (compared to his 9/6/23 weight of 181.0#). Resident #6 continued to be followed-up by NP #1 with a visit for his blood pressure conducted on 3/27/24. At that time, NP #1's progress note indicated the resident's weight was 152.9#. A Nursing progress note dated 3/31/24 at 10:05 AM reported the resident was suspected as being depressed and continuing to have a poor appetite. An on-call provider was contacted on 3/31/24 with new orders received to administer 7.5 mg mirtazapine each night for 7 days and 1000 milliliters (ml) of 0.9% normal saline solution to be given intravenously (IV) as 100 ml per hour for hypovolemia (low blood volume). Mirtazapine is an antidepressant which also acts as an appetite stimulant. Another Nursing progress note dated 3/31/24 at 12:18 PM reported the resident refused to receive the intravenous fluids as ordered. The order for the IV fluids was subsequently discontinued. A review of Resident #6's March 2024 Meal Intake Record was conducted. The record included documentation of 80 meals during the month of March with the following results: --19% of the meals were refused; --29% of the meals were reported to have 0 - 25% of the meal eaten; --17% of the meals were reported to have 26 - 50% of the meal eaten; --5% of the meals were reported to have 51 - 75% of the meal eaten; --30% of the meals were reported to have 76 - 100% of the meal eaten. A review of Resident #6's EMR included his March 2024 MAR. The March MAR revealed Resident #6 refused his liquid protein supplement 24 times during the month. The resident's EMR included a progress note dated 4/1/24 which revealed he was seen by NP #1 due to his decrease in appetite, depressed mood, and refusal of medications. Resident #6 was reported to be refusing intravenous fluids, medications, labs, and/or hospitalization . An NP's progress note dated 4/2/24 reported that upon receiving input from a family member, Resident #6 agreed to be transferred to the hospital Emergency Department (ED) on 4/2/24 for evaluation and treatment. A review of Resident #6's EMR revealed there were no additional nutritional assessments or notes documented by the facility's RD since the resident's last review dated 9/19/23. It was also noted there were no Dietary Progress Notes documented by the Certified Dietary Manager (CDM) for Resident #6 within the past 6 months. A review of Resident #6's Hospital Emergency Department (ED) Provider Notes indicated his recent history included failure to thrive and decreased oral intake. His hospital Discharge Summary dated 4/11/24 included the following note: .Unclear what his weight trend [was] but BMI 21 . (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 4/30/24 at 11:27 AM with NP #1. During the interview, NP #1 reported the resident was his own Responsible Party (RP) and he refused several interventions during the last few weeks of his stay at the facility. His refusals included medications, intravenous fluids, and hospitalization. She also reported the resident had verbalized to her that he was depressed, and both she and the nursing staff thought his poor oral intake may have been related to depression. When asked if the facility did what they could to encourage the resident's oral intake, the NP stated, I think so. We were trying our best. An interview was conducted on 4/30/24 at 2:44 PM with Nurse Aide (NA) #5. NA #5 reported she was routinely assigned to care for Resident #6 on first shift from 7:00 AM - 7:00 PM. The NA stated the resident could feed himself but required a set-up with meals. The NA reported that when she delivered meals to Resident #6, he would say, Just leave it there, I'll eat it. However, when she returned to pick up the meal tray, she noticed he wasn't eating very much so she would try to leave a few food items that were safe to keep on his bedside tray table. She reported sometimes Resident #6 would snack between meals. Upon inquiry, the NA stated the resident did not refuse care. An interview was conducted on 4/30/24 at 3:00 PM with Nurse #12. Nurse #12 reported she was typically assigned to care for Resident #6 on first shift from 7:00 AM - 7:00 PM. During the interview, the nurse recalled the resident wouldn't eat or drink much but when his family member asked him about it, he said he did fine. Nurse #12 added, but his body didn't lie. She reported the resident was obviously losing weight and did not appear to be well hydrated. The nurse stated she shared her concerns with NP #1. An interview was conducted on 5/1/24 at 3:10 PM with Nurse #13. Nurse #13 also reported Resident #6 resided on her usual hall assignment and she was very familiar with him. The nurse recalled the resident was refusing several medications in his last few weeks at the facility. She reported he seemed to be very depressed, and the resident stated he thought the medications were making him worse. Upon inquiry, Nurse #13 reported Resident #6 could feed himself. She added that both she and his NA would frequently try to help him with feeding, but the resident simply did not want to eat. An interview was conducted on 5/1/24 at 9:45 AM with the facility's Certified Dietary Manager (CDM). During the interview, the CDM reported he did not have a February 2024 weight for Resident #6. When asked, the CDM reported that if a resident's monthly weight reflected a significant weight loss, the resident would be reviewed in the next weekly Risk Meeting. The CDM stated he thought he had seen Resident #6 a couple of times within the last several months to obtain his food preferences. However, he acknowledged these interactions with the resident were not documented and he could not provide any additional details on when the interactions occurred or what information was obtained. When asked if any trials of nutritional supplements were attempted, the CDM stated the only supplement Resident #6 received was a liquid protein supplement administered by the nursing staff (initiated in September 2023). (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A telephone interview was conducted on 5/1/24 at 9:58 AM with the facility's consultant Registered Dietitian (RD). During the interview, the RD reviewed her notes for Resident #6 and reported she had completed a nutritional assessment for him in September of 2023. The RD stated that no other issues had been brought to her attention about Resident #6 since that time. She reported no one had told her the resident was having a poor intake and we missed the February weight. The RD further explained she did not become aware of a concern for this resident until his 3/25/24 weight became available. When the RD saw his March weight, Resident #6 had already been discharged to the hospital. The RD reported the facility had gone through a transition with their procedures for obtaining monthly weights for its residents. For a few months, the Unit Managers had taken the lead for obtaining and documenting the residents' weights. However, the facility recently recognized there was an issue with missing resident weights, so the process was again revised. When asked, the RD stated all newly admitted residents were weighed upon admission to the facility, weekly for 4 weeks (or until his/her weight was stable), and monthly thereafter. The RD reported the facility's policy indicated residents' weights should be obtained at least monthly. An interview was conducted on 5/1/24 at 8:25 AM with the Restorative NA who currently assumed responsibility for obtaining residents' weights. During the interview, the Restorative NA reported she has been obtaining the residents' weekly and monthly weights since the end of March 2024 and documenting these weights in the facility's electronic medical records. The NA reported if a resident either lost or gained 5 pounds compared to his/her previous monthly weight, she would reweigh the resident the following day. If a resident refused to be weighed, she would let the facility's Director of Nursing, RD, and nurse on the hall about the refusal. When asked what prompted Resident's #6's weight to be obtained on 3/25/24, the NA stated she weighed the resident on that date to get his March monthly weight. The NA reported since there wasn't a February weight for this resident, she would not have noticed that he had a significant weight loss and therefore, she would not have alerted the RD or nurse of a weight loss at that time. Upon further inquiry as to whether Resident #6 was resistant to being weighed, the NA stated to her knowledge, Resident #6 did not refuse to be weighed. An interview was conducted on 5/1/24 at 11:18 AM with the Regional Director of Operations. During the interview, the Director stated: It was identified in the QAPI [Quality Assurance and Performance Improvement Process] and review of the February data that the center failed to document weights and refusals to obtain weights. She also reported that as a result, there was a systemic change in the monitoring of the weights. A new process was implemented by the DON [Director of Nursing] and increased monitoring was noted with At Risk Meetings and routine QAPI [review]. The facility's Plan of Correction (POC) related to obtaining residents' weights was provided and reviewed. When asked, the Regional Director of Operations acknowledged the POC did not include all the information required for an acceptable plan of correction. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 5/1/24 at 1:13 PM with the facility's Director of Nursing (DON). At that time, the DON discussed the facility's procedures for obtaining resident weights. The DON reported all newly admitted residents were weighed upon admission to the facility, weekly for 4 weeks, and then monthly (depending on his/her clinical presentation and/or weight history). The DON stated the NA completing monthly weights was educated to report a resident's weight change to the RD and DON if the change was more than 5% in 30 days, 7.5% in 3 months, or 10% in 6 months. The DON reported that any resident with a significant weight change would be reviewed so the change could be addressed and monitored. She also reported if a resident refused to be weighed, this refusal needed to be reported to a nurse so it could be documented in the resident's progress notes. The DON reported she understood the facility's POC related to obtaining resident weights did not contain all the required components. An interview was conducted on 5/1/24 at 12:05 PM with the facility's Interim Administrator in the presence of the Regional Director of Operations. During the interview, the Regional Director of Operations confirmed she had informed the Administrator of the concern regarding a failure to monitor Resident #6's weight. When asked, the Administrator acknowledged he was aware the POC provided by the facility related to this topic did not include all the information required for an acceptable plan of correction.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33778 Based on record review, staff and Nurse Practitioner (NP) interviews, the facility failed to provide a physician's order for the use of a BIPAP (bilevel positive airway pressure) machine treatment for 1 of 1 resident (Resident #11) reviewed for respiratory services. Findings included: Resident #11 was readmitted to the facility on [DATE] and discharged on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (COPD), sleep apnea, congestive heart failure. Records review revealed the hospital's discharge summary, dated 2/21/24, indicated the recommendation to continue using the BIPAP (bilevel positive airway pressure) machine with specific inspiration and expiration settings at night. Review of Resident #11's admission Minimum Data Set assessment, dated 2/27/24, indicated that the resident was cognitively intact. The Special Treatment and Programs section of this assessment was not coded for BiPAP. Review of Resident #11's plan of care, dated 3/7/24, indicated resident's altered respiratory status, difficulty breathing, related to COPD and congestive heart failure, with interventions, not including CPAP or BIPAP treatment. Review of Resident 11's current physician orders revealed no order for BIPAP treatment. Review of Resident 11's Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed no entry to apply BIPAP treatment. On 4/30/24 at 10:15 AM, during an interview, Nurse Practitioner (NP #1) expected the physician order from the discharge summary, dated 2/21/24 for BiPAP treatment at night to have been transcribed and followed. NP #1 indicated that due to COPD, sleep apnea and congestive heart failure, it would be beneficiary for Resident #11 to use the BiPAP machine, and the order should have been included in Resident #11's medical records. On 5/1/24 at 1:45 PM, during the phone interview, Nurse #2 indicated that at admission, on 2/21/24, the BiPAP machine was ready for Resident #11 in her room. The resident used the BiPAP in the past, required assistance to apply the face mask of breathing machine and could remove it herself. Nurse #2 stated there should be a physician order for BiPAP treatment in the medical records, but she did not see the orders in Resident #11's medical records or in the MAR. As the admission nurse for Resident #11, Nurse #2 was responsible for transcribing the BiPAP order. On 5/1/24 at 12:10 PM, during the phone interview, Nurse #3 indicated that Resident #11 had the BiPAP machine in her room, but Nurse #3 did not recall seeing any orders regarding the BiPAP treatment in medical records or in the MAR. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/24 at 2:20 PM, during an interview, the Director of Nursing indicated that there should have been physician's order for BiPAP treatment in the medical records, transcribed into MAR. On 5/1/24 at 2:30 PM, during an interview, Assistant Administrator expected to have the physician's order for breathing machine treatment in place at admission.		