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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 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. (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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE] with diagnoses including diabetes mellitus and end stage renal disease. Resident #104's smoking assessment dated [DATE] indicated Resident #104 was a unsupervised smoker. (continued on next page)

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

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 [DATE] 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 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 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. (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 #104 on his leg and called Resident #104 bitches. (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 other. 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. 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. 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 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. 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. (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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, 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. 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. 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 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. (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. 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 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. 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, 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. 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 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. 20906 (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #47 was admitted to the facility on [DATE] 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 [DATE] indicated Resident #47 was severely cognitively impaired with cognitive communication deficit and behaviors. Resident #17 was admitted to the facility on [DATE] with the diagnoses of metabolic encephalopathy, dementia, cerebral vascular accident, epilepsy, chronic obstructive pulmonary disease, schizophrenia, and lung cancer and cognitive communication deficit. The quarterly Minimum Data Set (MDS) dated [DATE], indicated Resident #17 was severely cognitively impaired and no behaviors. 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. 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 were completed. 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. (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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 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. (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. 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 educated on resident-to-resident behaviors, abuse, neglect in [DATE] 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: (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. 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. 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. 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. (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Address how the facility will identify other residents at risk and determine if there were any identified problems for those residents: All residents were at risk. Resident interviews were completed with residents with a brief interview for mental [TRUNCATED]

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32394 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. The findings included: Resident #8 was admitted to the facility on [DATE] 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 (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 [DATE] 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 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. (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 provided an Active Inventory list of medications currently available in the emergency medication box. These medications included 14 tablets of 2.5 mg apixaban.

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38077 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. Findings included: Resident was admitted on [DATE] with diagnoses that included type 2 diabetes mellitus, peripheral vascular disease, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia and dependent on supplemental oxygen. 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. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed as cognitively intact. Resident #65 was assessed as a smoker and was on oxygen therapy. 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 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. (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. 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. 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 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 responsible for providing the smoking materials to the residents. The facility had 24-hour smoking aides available for residents. (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 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. 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.

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 32394 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 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). 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 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: This tag is cross referred to: F880 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. (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 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 procedures for glucometer disinfection and did not know which products were approved for disinfection. (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 - Blood glucose testing strips - Disinfecting wipes - Paper towels or tissues b. Complete Glucometer Procedure and Cleaning Steps: - Obtain needed equipment and supplies - Perform hand hygiene - Explain the procedure to the resident - Provide privacy (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- [NAME] gloves - Obtain capillary blood glucose sampling - Remove and discard gloves, perform hand hygiene prior to exiting the room - Retrieve (2) disinfectant wipes from container - Using the first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer - After cleaning, disinfect with second wipe, maintaining 3-minute wet contact time. Allow the glucometer to air dry - Discard disinfectant wipes in waste receptacle - Perform hand hygiene - Ensure glucometer is stored in individual plastic bag for each resident to prevent cross contamination - Place clean dry paper towel or tissue under glucometer before placing on resident table or on top of medication cart to prevent contamination 2. Competency Validation Process: Direct observation by nurse management of: - 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 3. Ongoing Monitoring: - The Director of Nursing maintains documentation of all completed competency validations (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The staffing coordinator verifies completion of glucometer competency before scheduling 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 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 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 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. (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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.

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32394 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 [DATE]. 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 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 [DATE]. 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 were administered to Resident #8. (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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).

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38129 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. Findings included: 1. Resident #185 was admitted to the facility on [DATE] 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 [DATE]. 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. 20906 2. Resident #70 was admitted to the facility on [DATE] with the diagnosis of type 2 diabetes mellitus, stage 4 prostate cancer and Lupus. The quarterly Minimum Data Set(MDS) dated [DATE] 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 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. 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. (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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 received the pain medication much later than scheduled and there would be late documentation. 38077 3. Resident #187 was admitted to the facility on [DATE]. Review of the discharge return not anticipated Minimum Data set assessment dated [DATE] 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 [DATE] 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), 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.