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	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	303 East Carver Street Durham, NC 27704

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52749 Based on record review, and staff and Responsible Party (RP) interviews, the facility failed to notify the Responsible Party (RP) of Resident #1's change in condition after a new diagnosis of peripheral vascular disease (PVD) with the lack of pedal pulses in both feet and failed to notify the Medical Director, who was the resident's attending physician, of a new diagnosis of PVD, and failed to notify the Medical Director of the identification of a new wound and transfer to the hospital for 1 of 8 residents (Resident #1). The findings included: 1a. Resident #1 was admitted on [DATE] with a diagnosis of diabetes mellitus, dementia, contractures of the right knee, left wrist, left hip, and left knee, malnutrition, and hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) affecting the left side of the body. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #1 was severely cognitively impaired. Review of a Podiatry Consult note dated 1/30/2025 revealed Resident #1 was given a new diagnosis of PVD. The consultation note also discussed lack of pedal pulses in both feet. A review of Resident #1's medical revealed no documentation that Resident #1's RP was informed of Resident #1's new diagnosis of PVD or that the resident had absent pedal pulses. An interview was conducted with the Podiatrist on 5/20/2025 at 10:45AM. The Podiatrist stated that Resident #1 presented physically with signs and symptoms of PVD based on a clinical assessment. The Podiatrist further stated during the visit on 1/30/2025 Resident #1 had no pedal pulses in both feet, capillary fill time (the time it takes for blood to flow to a specific area after pressure is released) was +3 seconds (normal time is less than 2 seconds) bilaterally, staining of the skin, thickening of nails, and all signs and symptoms of PVD. The Podiatrist had not informed Resident #1's RP of the new diagnosis of PVD because she expected the facility staff to inform the RP. Review of medical record revealed an order on 4/30/2025 at 1:00PM to transfer Resident #1 to the emergency room for wound on right smallest toe one time. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #1's hospital records dated 4/30/2025 revealed Resident #1 received a diagnosis of high fever, severe sepsis likely to infection of right fifth toe possible osteomyelitis. An interview conducted with Resident #1's RP over the telephone on 5/14/2025 at 11:09AM. The RP stated that on 4/30/25 the facility called her and informed her that Resident #1 needed to go to the hospital because of a fever and a wound. The RP requested more information from the facility and stated she did not receive any more information. The RP stated that she attended a care conference with the facility over the telephone on 4/8/2025 and there was no mention of any wounds or diagnosis of PVD with Resident #1. The RP stated she was not informed of Resident #1 having a lack of pedal pulses. The RP indicated she came to the facility after Resident #1 was admitted to the hospital and spoke with the Director of Nursing (DON) to inquire about Resident #1's wound development. An additional interview was conducted with Resident #1's RP over the telephone on 5/19/2025 at 3:24PM. The RP was unaware of the diagnosis of PVD and stated she was never informed of any vascular disease or any new diagnosis. The RP stated that the only time she was informed Resident #1 had any skin issues was the day Resident #1 was sent to the emergency roiagnom on [DATE]. An interview occurred with the Social Service Coordinator on 5/20/2025 at 10:06AM. The Social Service Coordinator stated there was a care conference on 4/8/2025 via telephone with the RP to discuss Resident #1's individual care plan. The Social Service Coordinator discussed not being aware of Resident #1's new diagnosis of PVD or that Resident #1 had a lack of pedal pulses. She stated she discussed with the RP Resident #1's care plan which she stated did not include any goals or interventions related to Resident #1's diagnosis of PVD or lack of pedal pulses. The Social Service Coordinator stated when a consultation was completed, the provider would give her any new orders that she would then deliver to the Unit Manager/nurse. She explained if the provider of the consultation did not have any orders, the provider would upload their consultation directly into the facility's electronic computer system. The Social Service Coordinator did not view the Podiatry note from 1/30/2025 for Resident #1. An interview was conducted with the Director of Nursing (DON) on 5/15/2025 at 6:27AM. The DON stated that she had a conversation with the RP at the facility regarding Resident #1's wound after he was admitted into the hospital. The DON did not state to the RP that Resident #1 had a diagnosis of PVD. The DON discussed the RP should have been made aware of the new diagnosis by the Medical Director. The DON indicated consultations were available on their computer system to be reviewed by any staff member. She stated once the consultation documentation was available in the computer system, the Medical Director should have been informed and was not. The DON was not able to speak to who would or should review consultations and inform the Medical Director of any changes in a resident's diagnosis/change of condition. b. Review of the medical record revealed no documentation the Medical Director was notified of Resident #1's new diagnosis of PVD or the lack of pedal pulses after his Podiatry consultation on 1/30/25. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted with the Medical Director on 5/14/2025 at 1:23PM. The Medical Director stated she was not aware of the new wound on Resident #1's right foot or being transferred to the hospital on 4/30/25 until 5/14/2025. The Medical Director discussed not being informed of Resident #1's new diagnosis of PVD or the lack of pedal pulses. She also stated she was not aware Resident #1 had been seen by a Podiatrist in January 2025. The Medical Director stated she had not looked at the consultations that were in the facility's computer system. An interview was conducted with the Director of the Nursing (DON) on 5/15/2025 at 6:27AM. The DON did not know if notification was made to the Medical Director of Resident #1's change in condition and new diagnosis of PVD and lack of pedal pulses from the 1/30/2025 Podiatry Consult. The DON indicated she did not notify the Medical Director of Resident #1's transfer to the hospital on 4/30/2025 until 5/14/2025.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 38920 Based on observation and staff interviews, the facility failed to protect residents' healthcare information by leaving confidential medication information unattended, visible, and accessible to others on the computer screen for 2 of 5 (upper and lower medication carts on the 100-hall) medication carts observed. Findings included: A continuous observation of the upper 100-hall medication cart occurred on 5/15/25 at 5:15am. The medication cart was in the hallway unattended, and it was observed to have the computer screen showing resident information such as resident name, resident diagnosis, medications, date of birth, and room number. The medication cart was observed for 3 minutes and during that time 2 Nursing Assistants walked past the cart. Nurse #5 was interviewed on 5/15/25 at 5:18am. Nurse #5 confirmed she was the nurse responsible for the upper 100-hall medication cart. The nurse immediately stated she knew what was wrong and said, I should have put the privacy screen up on the computer. Nurse #5 explained she did not think about completing the task before leaving the cart to provide medication to a resident. A continuous observation of the lower 100-hall medication cart occurred on 5/15/25 at 5:20am. The observation revealed the computer screen showed resident information such as resident name, resident diagnosis, medications, date of birth, and room number. The medication cart was observed for 3 minutes and during that time 2 Nursing Assistants had walked past the cart. Nurse #1 was interviewed on 5/15/25 at 5:23am. Nurse #1 confirmed she was the nurse responsible for the lower 100-hall medication cart. The nurse explained she was an agency nurse but was aware she should have placed the computer screen on the privacy screen prior to walking away. Nurse #1 stated, I just didn't think about it. The Director of Nursing (DON) was interviewed on 5/15/25 at 6:38am. The DON explained that the Quality Assurance Nurse was responsible for the education but stated she was not sure what education was provided. She further explained that each shift had a shift supervisor who was responsible for ensuring staff were following facility rules. The DON stated she did not know why Nurse #5 and Nurse #1 left their computer screens open to resident information. During an interview with the Quality Assurance Nurse on 5/15/25 at 8:33am, the Quality Assurance Nurse explained that the Unit Managers were responsible for education staff on their specific job assignments. The Administrator was interviewed on 5/15/25 at 1:43pm. The Administrator discussed staff needing to take responsibility for their actions and in keeping the residents safe. He stated he could not say why Nurse #5 and Nurse #1 had left their computer screens showing resident information.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38920 Based on record review, staff, and resident interviews, the facility failed to implement their grievance policy and procedures when Resident #2 reported his catheters and wheelchair charger were missing for 1 of 3 residents reviewed for grievances (Resident #2). Findings included: The facility's policy titled Grievances/Complaints, Filing which was not dated read in part Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff. The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the residents and/or representatives. Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint Resident #2 was admitted to the facility on [DATE] with diagnoses of heart failure and paraplegia (paralysis that can affect all or part of the trunk and legs). The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #2 was cognitively intact and was documented as having an electric wheelchair. Resident #2 was interviewed on 5/14/25 at 10:18am. The resident discussed he had a box of self-Cath catheters in his room and stated while he was sleeping someone came in and took them. Resident #2 also discussed someone taking his electric wheelchair charger. The resident explained that this happened about 2 weeks ago and that he informed the Director of Nursing (DON) and the Administrator immediately. Resident #2 voiced being upset because he had not heard of any resolution and he still did not have his self-Cath catheters or his electric wheelchair charger. During an interview with Unit Manager #1 on 5/15/25 at 1:00pm, the Unit Manager discussed Resident #2 had informed her about 2 weeks ago that his self-Cath catheters were missing along with his charger for his electric wheelchair. She explained that she immediately told the Social Worker and the Administrator but had not filled out a grievance form. The Unit Manager stated she had attempted to find the items herself but was unable to locate them. The Social Worker (SW) was interviewed on 5/15/25 at 1:21pm. The SW confirmed Resident #2 was on her case load. She stated about 2 weeks ago she was informed by Unit Manager #1 that Resident #2 self-Cath catheters were missing but was also told that nursing was ordering him new ones, so she did not fill out grievance or follow up. The SW discussed not learning about the charger for Resident #2 electric wheelchair until today. She stated she could not recall Unit Manager #1 telling her 2 weeks ago and that she learned about the charger from the resident today. The SW stated she did fill out a grievance today for the catheters and the charger. She explained that anyone can file a grievance. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 5/15/25 at 1:35pm, the Administrator stated he had not heard about Resident #2 missing items 2 weeks ago. He explained Resident #2 had told him about his missing self-Cath catheter and his charger for his wheelchair on 5/9/25. The Administrator stated he did not think every concern needed to have a grievance filed but confirmed that concerns/grievances needed to be resolved within 5 days. He stated he ordered Resident #2's self-Cath catheter's today, and that staff are continuing to look for the charger. He stated the resolution for the charger was not yet determined. The Administrator stated he would have expected a grievance to be filed once the items had not been found and stated that 2 weeks was too long to go without a resolution.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52749 Based on record review, and staff and family interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for a resident's active diagnosis of peripheral vascular disease (PVD) for 1 of 8 residents whose Minimum Data Set was reviewed (Resident #1). The findings included: Resident #1 was admitted on [DATE] with a diagnosis of diabetes mellitus, dementia, contractures of the right knee, left wrist, left hip, and left knee, protein malnutrition, and hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) affecting the left side of the body. Review of a Podiatry Consult note dated 1/30/2025 revealed Resident #1 was given a new diagnosis of PVD. An interview was conducted with the Podiatrist on 5/20/2025 at 10:45AM. The Podiatrist stated that Resident #1 presented physically with signs and symptoms of PVD based on a clinical assessment. The Podiatrist further stated during the visit on 1/30/2025 Resident #1 had no pedal pulses in both feet, capillary fill time (the time it takes for blood to flow to a specific area after pressure is released) was +3 seconds (normal time is less than 2 seconds) bilaterally, staining of the skin, thickening of nails, and all signs and symptoms of PVD. The quarterly Minimum Date Set (MDS) assessment dated [DATE] indicated Resident #1 was severely cognitively impaired. The MDS did not indicate Resident #1 was diagnosed with PVD. An interview was conducted with the Social Service Coordinator on 5/20/2025 at 10:06AM. The interview indicated that the Social Service Coordinator received the written consultations and if there was an order from the consultation, the order was given to the Unit Manager. The Social Service Coordinator discussed that once she received the consultation, she would give the consultation to medical records who would then upload the consultation into the electronic health care system. The Social Service Director was not able to confirm if any new diagnosis for Resident #1 from his podiatry visit was added to the MDS as an active diagnosis but stated the MDS nurses have access to the consultations. A telephone interview with MDS Nurse #2 and MDS Nurse #1 on 5/20/2025 at 11:26AM revealed they were both unaware of the diagnosis of PVD for Resident #1. The MDS Nurses reviewed the quarterly MDS dated [DATE] and the diagnosis of PVD was not marked for Resident #1. During the interview with MDS Nurse #2 and MDS Nurse #1, they stated that for a diagnosis to be coded on the MDS it must be active in the last 60 days and there needed to be treatment for the diagnosis. MDS Nurse #2 stated that she spoke with her Regional MDS consultant and who felt that not coding the 4/11/2025 quarterly MDS with a diagnosis of PVD was accurate. MDS Nurse #2 and MDS Nurse #1 explained they reviewed the residents' medical records, including consultations for any new information.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52749 Based on record review, and staff and Medical Director interviews, the facility failed to ensure that during provider visits the provider reviewed the total plan of care for 1 of 8 residents (Resident #1) newly diagnosed peripheral vascular disease (PVD). Resident #1 was examined by the Medical Director and the Medical Director failed to recognize Resident #1 did not have active pedal pulses in both feet. An interview with the Medical Director revealed that there was no examination of the feet during her visit on 3/25/2025. Resident #1 needed an assessment of his feet based on the new diagnosis of PVD to recognize the need for further treatment, review the plan of care, and consultations. This deficient practice occurred for 1 of 3 residents reviewed for Physician visits (Resident #1). The findings included: Resident #1 was admitted on [DATE] with a diagnosis of diabetes mellitus, dementia, contractures of the right knee, left wrist, left hip, and left knee, malnutrition, hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) affecting the left side of the body and PVD. A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 was severely cognitively impaired and unable to make decisions for himself. Record review of the Podiatrist consult note from 1/30/2025 were obtained for review. The Podiatrist notes stated Resident #1 was newly diagnosed with, indicated peripheral vascular disease. Patient was not a referral to a vascular surgeon as they do not meet any one of the following guidelines for referral: 1. Critical limb ischemia, 2. Claudication that affects quality of life, 3. Symptoms are unresponsive to conservative management. They do however, meet the qualifications for routine or at risk footcare. Further record review of the Podiatrist clinical note indicated that Resident #1 had Pedal pulses absent in both feet, Capillary refill +3 seconds, and pigmentary changes on both feet. An interview was conducted on 5/19/2025 at 4:02PM with Nurse #3. Nurse #3 indicated that when a consultation was received from a provider the licensed nursing staff would give information to the medical director if needed. Nurse #3 further revealed that they would contact the Medical Director by phone, place information in the provider's book, and/or copy of the order left for the provider. Nurse #3 was asked if the Medical Director was notified of the new diagnosis of PVD for Resident #1 and she could not recall. Resident #1 was last evaluated by the Medical Director on 3/25/2025. Review of the progress notes revealed general information about medications and diagnosis but there was no follow up plan or discussion of Resident #1's recent diagnosis of PVD. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Medical Director on 5/14/2025 at 1:23PM. The Medical Director confirmed she last saw Resident #1 on 3/25/2025. The Medical Director stated she reviewed Resident #1's medications and progress notes. She discussed examining Resident #1 at that time but had not looked at his feet or felt for pedal pulses (pulses that are on the top of the foot). The Medical Director stated she was unaware the Podiatrist had seen Resident #1 in January 2025, so she had not reviewed the consultation. She discussed not being aware, from the Podiatrist consultation, that Resident #1 did not have any pedal pulses in his feet or that the Podiatrist had diagnosed Resident #1 with a new diagnosis of PVD. She further discussed not being made aware by the facility staff that Resident #1 had the Podiatrist consultation or the findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 38920 Based on observation and staff interviews, the facility failed to secure residents' medications in a locked medication cart for 2 of 5 (upper and lower carts on hall 100) medication carts reviewed. Findings included: a. A continuous observation of the upper 100-hall medication cart occurred on 5/15/25 at 5:15am. The medication cart was in the hallway unattended and was observed to have a resident's insulin pen sitting on top of the cart, the cart was unlocked, and the bottom drawer of the medication cart was open. The medication cart was observed for 3 minutes and during that time 2 Nursing Assistants walked past the cart. Nurse #5 was interviewed on 5/15/25 at 5:18am. Nurse #5 confirmed she was the nurse responsible for the upper 100-hall medication cart. The nurse immediately stated she knew what was wrong and said, I should have put the medication away, closed the drawer and locked my cart. Nurse #5 explained she did not think about completing the tasks before leaving the cart to provide medication to a resident. b. A continuous observation of the lower 100-hall medication cart occurred on 5/15/25 at 5:20am. The observation revealed the cart was unlocked. The medication cart was observed for 3 minutes and during that time 2 Nursing Assistants had walked past the cart. Nurse #1 was interviewed on 5/15/25 at 5:23am. Nurse #1 confirmed she was the nurse responsible for the lower 100-hall medication cart. The nurse explained she was an agency nurse but was aware she should have locked her medication cart prior to walking away. Nurse #1 stated, I just didn't think about it. The Director of Nursing (DON) was interviewed on 5/15/25 at 6:38am. The DON explained that the Quality Assurance Nurse was responsible for the education but stated she was not sure what education was provided. She further explained that each shift had a shift supervisor who was responsible for ensuring staff were following facility rules. The DON stated she did not know why Nurse #5 and Nurse #1 left their medication carts unlocked. During an interview with the Quality Assurance Nurse on 5/15/25 at 8:33am, the Quality Assurance Nurse explained that the Unit Managers were responsible for educating staff on their specific job assignments. The Quality Assurance Nurse stated she did not know what education was provided to the employee by the Unit Managers. The Administrator was interviewed on 5/15/25 at 1:43pm. The Administrator discussed staff needing to take responsibility for their actions and in keeping the residents safe. He stated he could not say why Nurse #5 and Nurse #1 had left their medication carts unlocked.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. 38920 Based on record reviews, observations, and interviews with staff and the Medical Director, the facility staff failed to utilize a resident's assigned blood glucose meter (glucometer) and instead used a loose, unassigned, and unlabeled glucometer located in the medication cart to check Resident #8's blood glucose (sugar) level. In addition, the staff member did not disinfect the glucometer before or after obtaining Resident #8's blood glucose level and would have had no way to know if another staff member had previously disinfected the loose, unassigned, and unlabeled glucometer. This occurred while there were 11 residents identified with a known bloodborne pathogen in the facility with 4 of the 11 residents requiring blood glucose levels. Loose, unlabeled glucometers can be contaminated with blood and must be 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 has the high likelihood to expose 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. The deficient practice occurred for 1 of 3 residents observed to have his blood glucose (sugar) level checked (Resident #8). Immediate jeopardy began on 5/15/25 when Nurse #1 was observed to perform blood glucose testing for Resident #8 using a loose, unlabeled, unassigned glucometer without disinfecting the glucometer. Immediate jeopardy was removed on 5/16/25 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 the facility to complete agency and employee staff training with monitoring to ensure appropriate interventions are put into place. Findings included: The facility's policy and procedure titled Obtaining a Fingerstick Glucose Level that did not contain a date read under the title Steps in the Procedure always ensure the blood glucose meter intended for reuse is clean and disinfected between resident use following the manufacturers instructions and the current infection control standards of practice. The manufacturer instructions for cleaning and disinfecting the (Brand Name) glucometer used at the facility were summarized in a Technical Brief (Revised 9/24). The Technical Brief read in part, To minimize the risk of transmitting bloodborne pathogens, the cleaning and disinfecting procedures should be performed as recommended in the instructions below. The (Brand Name) meter may only be used for testing multiple patients when standard precautions and the manufacturer's disinfecting procedures are followed. The meter should be cleaned and disinfected after use on each patient. The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfecting procedure. The disinfecting procedure is needed to prevent the transmission of bloodborne pathogens .Clean and disinfect the meter following step-by-step instructions in the Quality Assurance (QA) / Quality Control (QC) Reference Manual. Cleaning and Disinfecting Procedures specified in the glucometer's QA/QC Reference Manual (Revised 10/24) included, in part: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	--Cleaning: Step 1 (of 7): Wear appropriate protective gear such as disposable gloves. Step 3 (of 7): Wipe the surface of the meter to clean blood and other body fluids . Step 4 (of 7): If blood is visible on the meter, it should be cleaned prior to each disinfection step. --Disinfecting: Step 5 (of 7): Pull out 1 new towelette and wipe the entire surface of the meter horizontally and vertically to remove bloodborne pathogens. Carefully wipe around the test strip port by inverting the meter so that the test strip port is facing down. Step 6 (of 7): Treated surface must remain wet for recommended contact time. Please refer to wipe manufacturer's instructions. The manufacturer's Technical Brief for the glucometer listed the disinfectant wipes used at the facility as one of the EPA-registered wipes recommended to clean and disinfect the (Brand Name) glucometer. The instructions on the label of the disinfectant wipes read in part: To clean and disinfect and deodorize hard, nonporous surfaces: Wipe surface to be disinfected. Use enough wipes to treat surface to remain visibly wet to the contact time listed. Let Dry. Special instructions for cleaning and decontamination against human immunodeficiency virus (HIV), hepatitis B and hepatitis C indicated, Allow surfaces to remain wet for one minute, let air dry. For all other organisms, see directions for contact time. The Director of Nursing provided education for Nurse #1. The education was dated 2/4/25 with a return competency completed on 2/5/25. The education titled glucometer testing included how to store, disinfect before and after each use, and using the resident's designated glucometer. A continuous observation from 5:10am to 5:25am occurred on 5/15/25 in the 100 Hall hallway. The observation revealed Nurse #1 walking away from her medication cart (lower 100-hall medication cart) with a glucometer in her hand. Nurse #1 entered Resident #8's room, stood on the left side of the bed, lifted the cover exposing Resident #8's left hand, the nurse wiped one finger on Resident #8's hand with an alcohol pad, used a lancet device to prick Resident #8's finger, and then held the glucometer (with the test strip already in the machine) to the resident's finger obtaining his blood sugar. Nurse #1 was observed to walk out of the resident's room, place the used lancet into the secure needle container, throw her gloves into the trash receptacle, and place the glucometer on top of the medication cart. The glucometer was observed to not have any label. At 5:15am, Nurse #1 was observed to place the glucometer in the top drawer of the medication cart without disinfecting it. Nurse #1 was observed for another 10 minutes with no other residents receiving blood sugar checks. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse #1 an agency nurse who worked the 7:00pm to 7:00am shift was interviewed on 5/15/25 at 5:25am. Nurse #1 discussed every resident having their own glucometers that were kept in the top drawer of the medication cart in a plastic container. Nurse #1 opened the top drawer of her medication cart and there was an individual plastic container labeled with each resident's name. There was also a loose unlabeled glucometer in one of the compartments on the left side of the drawer. Nurse #1 confirmed she had just obtained a blood sugar from Resident #8 with the loose unlabeled glucometer that was on the left side of the drawer. Nurse #1 showed the surveyor that Resident #8 had his own glucometer. She stated she had obtained the loose unlabeled glucometer from the bottom drawer of the medication cart. Nurse #1 explained she did not know why she had not used Resident #8's dedicated glucometer I don't know, I just saw this one and used it. She discussed not knowing if the glucometer was disinfected before she used it and stated she had not disinfected it herself prior to obtaining Resident #8's blood sugar. Nurse #1 also confirmed she had placed the glucometer back into the top drawer of the medication cart in the left compartment without disinfecting it. The nurse explained she did not disinfect it because she was going to take it to the nursing station to throw it away. She explained she was going to throw it away because Resident #8 already had his own. Nurse #1 stated she had received education on the proper care/disinfecting glucometers before and after use but said I'm agency. I don't work here all the time. She confirmed there was no visual cues on the medication cart to help her remember how/when to disinfect the glucometers and stated, I have never seen anything on the cart. Upon request, the facility provided a Diagnosis Report for its current residents (dated 5/15/25 at 9:42am). The Diagnosis Report indicated 11 residents were identified as having at least one bloodborne pathogen, which included hepatitis C and HIV. Upon review of the 11 residents, it was discovered that 4 of the residents required blood sugar monitoring with one (1) of the 4 residing on hall-100. The Quality Assurance Nurse/Infection Preventionist was interviewed on 5/15/25 at 8:33am. The Nurse explained that she was responsible for having staff sign an acknowledgement form on the computer that staff would adhere to all the facility's rules, expectations, and procedures. She stated the Unit Managers were responsible for any specific training for the nurses/staff. The Quality Assurance Nurse/Infection Preventionist confirmed Nurse #1 had signed the acknowledgement form. Observation of the lower 100-hall medication cart with Nurse #6 occurred on 5/15/25 at 9:43am. A loose unlabeled glucometer was observed in the bottom drawer of the medication cart in a small white basket. The observation also revealed there were EPA wipes present in the bottom drawer, but there was no visual cue cards present on the medication cart for disinfecting the glucometers. Nurse #6 was interviewed on 5/15/25 at 9:44am. Nurse #6 explained he worked the 7:00am to 7:00pm shift. The nurse confirmed there was a non-labeled loose glucometer in the bottom drawer of his medication cart. He explained the glucometer was for emergencies only and used only on non-diabetics. Nurse #6 discussed not knowing if the glucometer had been disinfected but stated, it should be cleaned before using. He was unable to answer how long it took to clean the glucometer. He stated he had never had to use the loose unlabeled glucometer. Nurse #6 stated he had received education on storing/disinfecting glucometers and stated he thought it was in February 2025. Nurse #6 confirmed there was no visual cues on the medication cart to help him remember how/when to disinfect a glucometer and said he did not remember ever seeing a visual cue on the medication cart. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview occurred with the Medical Director on 5/15/25 at 10:21am. The Medical Director discussed being aware of staff not disinfecting glucometers a few months ago but nothing recently. She stated the concern of not disinfecting glucometers before and after use was the spread of diseases. The Medical Director explained she expected staff to follow infection control practices when using glucometers. The Director of Nursing (DON) was interviewed on 5/15/25 at 11:31am. The DON explained during the facility's last annual survey in February 2025 there had been an issue with staff not disinfecting shared glucometers before and after use between residents. She stated when that occurred the facility began monitoring/auditing glucometer use to ensure staff were disinfecting as required, placed visual cue cards on the medication carts to help staff remember the steps in disinfecting the glucometers, and provided education to all the staff including agency staff. The DON also stated the facility purchased plastic cases and assigned each resident their own glucometer. The DON discussed the facility was continuing to do monitoring and audits of the medication carts for visual cue cards and ensuring each resident had their own glucometer. She stated this was being done by the Unit Managers and/or the Quality Assurance Nurse. She explained that no medication cart should have a loose unlabeled glucometer and was unaware there had been one on the lower 100-hall medication cart. The DON also stated she was not aware the visual cue cards were no longer present on the medication carts. She stated all staff including agency staff had been educated on glucometer use back in March 2025 and could not speak to why Nurse #1 had used a loose glucometer and not disinfected it. The DON stated Nurse #1 should have used Resident #8's designated glucometer and thrown away the loose unlabeled glucometer. The DON explained the loose unlabeled glucometer could be thrown away because if a staff member needed a new one, there were new ones located in the medication room. During an interview with the Administrator on 5/15/25 at 2:00pm, the Administrator explained during the facility's last annual survey in February 2025 there had been an issue with staff not disinfecting shared glucometers before and after use between residents. He explained right after the February survey, the facility purchased plastic containers and more glucometers so each resident could have their own designated glucometer, the facility began monitoring/auditing, and education was provided. The Administrator discussed the on-going monitoring and audits related to glucometer use. He also discussed the education that was completed and included agency staff. The Administrator stated this was an unforeseeable action and could not comment on what he thought caused Nurse #1 to not disinfect a glucometer. The facility's Administrator was informed of the immediate jeopardy (IJ) on 5/15/25 at 2:30pm. The facility provided the following plan for IJ removal: 1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: On May 15, 2025, it was observed that a facility staff member (an agency nurse) used an unlabeled glucometer (blood glucose meter) on Resident #8 without disinfecting the glucometer before or after use. The Director of Nursing (DON) promptly called and left a voicemail with the Responsible Party (RP) for Resident #8 regarding this incident. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Upon interview, the nurse stated she did not use that particular unlabeled glucometer for any other residents. The glucometer used was not a shared facility glucometer designated for multiple residents; rather, it was an unlabeled glucometer discovered in the medication cart. The nurse acknowledged her awareness that Resident #8 had an individually assigned, labeled, and properly stored glucometer present in the medication cart. She indicated she used the unlabeled glucometer because she was nervous about being observed by the surveyor. This agency nurse had received training on February 5, 2025, as part of a previous Directed Plan of Correction (DPOC). She stated she failed to disinfect the glucometer involved in the May 15, 2025, incident due to being nervous while under observation by the surveyor. The nurse's failure to use the individually assigned glucometer for Resident #8 and her failure to disinfect the unassigned glucometer before and after use are significant deviations from established infection control procedures. The facility's system mandates individually assigned glucometers for each resident requiring blood glucose monitoring. These glucometers are labeled with the resident's name, and each resident's glucometer is stored in an individual plastic container on the medication cart. The system failed in this instance because the unlabeled glucometer should not have been present in the medication cart, making it available for potential use, and the trained staff member failed to adhere to established procedures regarding use of resident-specific glucometer and proper disinfection. A review of resident records who were receiving blood glucose monitoring through the use of glucometers was conducted by the Minimum Data Set (MDS) Nurse on the morning of May 15, 2025. The review identified there were at least four residents currently residing in the facility, and having their blood glucose monitored with a glucometer, who had been diagnosed with one or more bloodborne pathogens. Failure to clean and disinfect shared or improperly maintained medical equipment, such as glucometers, according to manufacturer's instructions and with a disinfectant registered with the national environmental protection agency (EPA), created a significant risk of cross-contamination and exposure to bloodborne pathogens. Shared or improperly cleaned blood glucose meters can become contaminated with blood and bodily fluids. This practice potentially exposes any resident undergoing blood glucose monitoring with a shared, improperly disinfected device to the spread of bloodborne pathogens. Resident #8, and any other resident who the facility might have determined (though none were identified) to have had their blood glucose tested using an unassigned and improperly disinfected glucometer, are considered likely to suffer a serious adverse outcome (e.g., transmission of bloodborne pathogens) as a result of this noncompliance. An immediate audit was initiated on May 15, 2025, by the Director of Nursing (DON) to identify all residents requiring blood glucose monitoring and to ensure each had an individually assigned and properly labeled glucometer. This audit confirmed all residents requiring blood glucose monitoring had an individually assigned and properly labeled glucometer, and no other issues were identified. Immediate Actions Taken for Affected and At-Risk Residents (Completed: May 15, 2025): (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A series of immediate actions were completed on May 15, 2025, for affected and at-risk residents. Firstly, the medical provider for Resident #8 was notified of the potential exposure on May 15, 2025, by the DON. Secondly, the one unlabeled glucometer identified was immediately removed from the medication cart and discarded on May 15, 2025, by the DON, ensuring no further use was possible. Thirdly, an immediate inventory check was completed on May 15, 2025, by the DON and nursing leadership (Assistant Director of Nursing (ADON), Quality Assurance (QA) Nurse, Unit Managers), which confirmed that sufficient individually assigned, and resident-labeled, glucometers, and appropriate EPA-registered disinfectant wipes were available for all residents requiring blood glucose monitoring. Reporting (Completed: May 15, 2025): This infection control breach and the potential for exposure to bloodborne pathogens were reported to the local health department on May 15, 2025, by the Director of Nursing (DON). The health department recommendations included testing for Human Immunodeficiency Virus (HIV), Hepatitis B, and Hepatitis C for any potentially exposed residents. Action Taken on Health Department Recommendations (Completed: May 15, 2025): In response to health department recommendations, several actions were completed on May 15, 2025. Orders for baseline testing for HIV, Hepatitis B, and Hepatitis C were obtained from the medical provider for Resident #8. Subsequently, specimens for these ordered tests for Resident #8 were ordered on May 15, 2025, and collected on May 16, 2025, as per facility policy and state regulations. Any follow-up on results and further medical intervention for Resident #8 will be managed by their attending physician and documented in their medical record. The facility acknowledges this is a repeat Immediate Jeopardy (IJ) citation. A previous Directed Plan of Correction (DPOC) had been implemented. This DPOC included comprehensive training for all nursing staff, including the involved agency nurse on February 5, 2025, covering infection control practices for glucometer use. This training emphasized principles from established guidelines (e.g., statewide infection control and epidemiology guidelines (SPICE)), such as the use of single-use, auto-disabling disposable lancets; proper hand hygiene; individual assignment of glucometers; and correct disinfection of devices using EPA-registered wipes with appropriate contact time (noting alcohol pads are for skin preparation only and unsuitable for device disinfection). A thorough root cause analysis was conducted by the Administrator, Director of Nursing (DON), Regional Director of Operations, and Regional Nurse Consultant following the May 15, 2025, incident. The recurrence of the deficient practice was determined to be due to a combination of factors. Firstly, a System Failure in Glucometer Control occurred, as an unauthorized, unlabeled glucometer was present on a medication cart, indicating a weakness in previous inventory control processes. Secondly, Individual Staff Performance under Stress was a factor, wherein the individual agency staff member, despite prior training and knowledge of correct procedure (and the availability of the resident's assigned glucometer), failed to adhere to established and previously trained procedures when under the perceived pressure of surveyor observation. Thirdly, there was a lapse in Environmental Reinforcement, as visual aids related to glucometer procedures were not replaced by pharmacy staff after a medication cart upgrade, potentially weakening environmental reinforcement of correct procedures (though the nurse involved did not state this as a factor for her specific actions). (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The employment of the agency nurse involved in the incident was terminated by the Director of Nursing (DON) on May 15, 2025. No other staff members have been identified as committing the same deficient practice. 2. 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 were implemented to immediately alter the deficient practice, prevent recurrence, and ensure ongoing compliance, thereby removing the immediate jeopardy. All actions listed below were completed by the end of day on May 15, 2025, unless otherwise specified. System for Glucometer Control, Assignment, and Policy To strengthen the system for glucometer control, assignment, and policy, several actions were completed by May 15, 2025. Firstly, the facility's Glucometer Procedure: Use, Cleaning, and Infection Control was reviewed and updated. This procedure now reflects all current corrective actions, emphasizing the critical importance of using only individually assigned, labeled glucometers and adherence to new surveillance. Following this, all licensed nursing personnel acknowledged receipt and understanding of this updated policy and its implications for daily practice. This was presented by the DON and nursing leadership (ADON, QA Nurse, Unit Managers). Secondly, an initial system-wide glucometer audit was performed. A comprehensive audit was conducted by the DON and nursing leadership (ADON, QA Nurse, Unit Managers), ensuring every resident requiring blood glucose monitoring had an individually assigned, correctly labeled glucometer, stored in its designated clean, individual, hard container within the medication cart. As noted, this audit found no deficiencies. All unauthorized/unlabeled glucometers (the single one identified) were removed from circulation and discarded by the DON and nursing leadership. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Thirdly, a strict protocol for the introduction of new or replacement glucometers became effective May 15, 2025. The Director of Nursing (DON), or Nursing Leadership (ADON, QA Nurse, Unit Manager) in the DON's absence, is responsible for obtaining new glucometers for the facility. The Administrator notified and trained the DON on this new process on May 15, 2025. All new glucometers will be delivered directly to DON's office. The glucometers will then be labeled for a specific resident and distributed by the DON or Nursing Leadership (ADON, QA Nurse, Unit Manager) in her absence, before being placed into service on any medication cart. New glucometers not yet in use (unassigned) will be stored exclusively in the DON's office. No unassigned or unlabeled stock glucometers will be permitted to be stored on medication carts or in general nursing units outside of the DON office's control. For new admissions requiring a glucometer after hours or on weekends, the assigned nurse will notify the Unit Manager or other member of the nursing leadership team (ADON, QA Nurse), who will obtain the glucometer from the DON's office. In an emergency after hours, if a current resident suddenly requires a glucometer, the DON's office has an access code (communicated to nursing leadership: ADON, QA Nurse, Unit Managers, and Administrator); the nurse would notify the nursing manager on duty, who will obtain the glucometer from the DON office. Unused glucometers for discharged residents will be removed from the medication cart by the Unit Manager within 24 hours during routine audits and discarded. On May 15, 2025, the Administrator in-serviced the Central Supply Clerk regarding the new protocol, specifically that all glucometers were to be delivered to the DON office upon receipt at the facility. The DON and the nursing leadership team (ADON, QA Nurse, Unit Managers) were also included in this in-service and communication regarding the new glucometer control protocol. System for Maintaining Visual Aids and Equipment Management Effective May 15, 2025, laminated visual reminders outlining critical steps from the Glucometer Procedure: Use, Cleaning, and Infection Control policy, including disinfection steps, were reviewed and confirmed to be accurately placed on all medication carts and in medication rooms by the DON and nursing leadership. Furthermore, the facility's equipment management protocol has been updated. Following any medication cart modification, replacement, or significant repair that may impact visual aids, the Director of Nursing (DON) or Nursing Leadership (ADON, QA Nurse, Unit Manager) in her absence, is responsible for ensuring all necessary signage and visual aids, including the 'Glucometer Procedure: Use, Cleaning, and Infection Control' reminder cards, are promptly verified as present and correctly reinstalled before the medication cart is returned to service. The Administrator trained the Director of Nursing on this updated process. This ensures direct oversight by nursing leadership for this critical component. Education and Competency Validation All actions regarding education and competency validation were completed on May 15, 2025. Medication aides do not perform blood sugar checks and therefore are not included in this specific glucometer competency training. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carver Living Center	303 East Carver Street Durham, NC 27704

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ongoing Training requirements were established on May 15, 2025. This comprehensive education and competency validation will be incorporated into the orientation program for all new nursing hires and agency staff prior to them performing any resident care assignments independently. Annual competency refreshers will also be conducted. This training will be conducted by the DON or Nursing Leadership (ADON, QA Nurse, Unit Manager) in her absence, or the Staff Development Coordinator. A Tracking System was implemented. As of May 15, 2025, the DON, ADON, and scheduler were assigned responsibility for maintaining records of all completed training, signed acknowledgement forms, and competency validations. They are responsible for ensuring all nursing staff have completed the required training and demonstrated competency before they are assigned to resident care duties involving blood glucose monitoring. Ongoing Supervisory Support and Procedural Adherence Commencing May 15, 2025, and on an ongoing basis, the facility is committed to a comprehensive plan of direct supervisory support and surveillance of licensed nurses, including agency nurses, to ensure continued adherence to the correct blood glucose monitoring procedures. This will involve active engagement with all nursing staff performing this procedure, across all shifts (day, evening, night, and weekends). These supportive surveillance activities will be conducted by Nursing Leadership (DON, ADON, Unit Managers, Regional Nurse Consultant), ensuring a visible leadership presence and resource availability. This initiative focuses on creating supervisory moments through on-the-spot observation and evaluation of staff performance during act [TRUNCATED]