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	05/14/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility failed to provide a dignified dining experience by ensuring all residents seated at the same table were served their meals at the same time for 1 of 2 sampled residents (Resident #141).Findings included:Resident # 141 admitted on [DATE] with diagnosis that included Alzheimer's disease, peripheral vascular disease, chronic kidney disease, and blindness in the right eye.Record review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #141 was cognitively intact, required set-up or clean-up assistance with eating, and ambulated independently with a walker.Record review of Resident #141's care plan initiated 3/25/2026 revealed he required set-up or clean-up assistance with meals and received a therapeutic diet of no added salt for hypertension.Record review of the meal consumption report revealed Resident #141 consumed 75-100% of meals.Continuous observation of the 400 Hall dining room on 5/11/2026 from 12:45 PM through 1:15 PM showed Resident #141 sitting at a table with one other resident. The Dining Room Attendant served the tablemate first and then proceeded to serve other residents. Resident #141 sat and watched the others receive and eat their meals. The dining attendant served all other residents in the dining room before going out of the dining room at 1:05 PM and returned with Resident #141's tray at 1:10 PM, after the tablemate had finished his meal. During an interview on 5/11/2026 at 1:30 PM, Resident #141 stated he was mad that he was the last one served and that he had to watch everyone else eat and his tablemate finish lunch before he received his meal.During an interview on 5/12/2026 at 1:10 PM, the Dining Room Attendant stated they normally served each table at the same time; however, they had run out of the alternate meal and had to obtain one from another dining room for Resident #141.During an interview on 5/13/2026 at 12:45 PM, the Dining Room Supervisor stated that all residents seated at the same table should be served at the same time.During an interview on 5/14/2026 at 10:00 AM, the Director Nursing stated all residents at the same table should have been served at the same time.During an interview on 5/14/2026 at 11:00 AM, the Administrator stated the Residents at the same table should have been served at the same time.

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

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