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

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility failed to accommodate food preferences for 1 of 10 residents reviewed for food preferences (Resident #109).Findings included: Resident #109 was admitted on [DATE] with diagnosis that included hypertension.Record review of Physician orders dated 3/10/2026 revealed Resident #109 was prescribed a regular diet with thin liquids.Record review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #109 was cognitively intact. An observation of Resident #109's breakfast tray delivered to the room on 5/11/2026 at 9:30 AM identified bacon on the tray. Resident #109's dietary tray ticket revealed dislikes of pork, peppers, cheese, salt, and gravy. Observation of Resident #109's lunch tray delivered to the room on 5/13/2026 at 12:45 PM identified rice with gravy. Resident #109's dietary tray ticket revealed dislikes of pork, peppers, cheese, salt, and gravy. During an interview on 5/12/2026 at 9:14 AM, Resident #109 stated she received pork at meals several times in the past, although her tray ticket clearly identified her dislikes of pork, peppers, cheese, and gravy. Resident #109 stated she would eat what she could on tray and leave the disliked items on her tray. Resident #109 stated nurse aides would sometimes offer an alternate item when they picked up her tray, but not always. Resident #109 stated she had told several nurses and nurse aides that she does not eat pork or greasy food, but she still receives those items.On 5/13/2026 at 12:45 PM the Dining Room Supervisor and Dining Room Server were accompanied to Resident #109's room to observe the lunch tray that was served. The Dining Room Supervisor and Dining Room Server confirmed Resident #109's dislikes were listed on the tray ticket, and Resident #109's lunch tray contained rice with gravy. The Dining Room Supervisor obtained rice without gravy from the steam table for Resident #141 and stated the Dining Room Assistant should have read the tray cards to the Dining Room Server prior to plating the Resident's food.During an interview on 5/13/2026 at 12:50 PM, the Dining Room Assistant stated the Dining Room Assistants were supposed to read the residents' dislikes aloud to the Dining Room Server prior to plating each tray from the dining room steam table. The Dining Room Assistant stated Resident #141 dietary tray card identified the dislike of pork, peppers, cheese and gray. The Dining Room Assistant verified she had not read aloud the dislikes on Resident #141 tray card to the Dining Room Server on 5/13/2026.During an interview on 5/14/2026 at 10:00 AM, the Director of Nursing stated the Dietary Staff should verify the meal trays do not include a resident's dislike, and nurse aides delivering trays should verify tray cards and correct trays if dislikes were observed before the tray was delivered to the residents.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review and interviews with staff and the Medical Director, the facility failed to implement their infection control policies and procedures when Nurse #14 administered medications to Resident #112 through a gastrostomy tube (tube that enters through the abdominal wall into the stomach) and did not wear a gown and gloves and when Nurse #14 failed to wear gloves when handling Resident #75's glucometer after a finger stick with a blood sample on the test strip. The deficient practice occurred for 1 of 4 staff observed for infection control practices (Nurse #14). Findings included:1. The facility Enhanced Barrier Precautions policy dated August 2022 documented in part 3. Examples of high-contact resident care activities requiring the use of gown and gloves for enhanced barrier precautions include g. device care or use (central line, urinary catheter, feeding tube. On 5/11/26 at 10:00 am an observation and interview was completed of Nurse #14 when she checked placement and administered crushed medication into Resident #112's gastrostomy tube (feeding tube) without use of Personal Protective Equipment (PPE). There was signage on the resident's door for enhanced barrier precautions which instructed staff to wear a gown and gloves when accessing the gastrostomy tube and suprapubic catheter. There was PPE available just outside the resident's door. Nurse #14 stated, they are all like that the resident's doors have signage. Nurse #14 commented she was new to long-term care and this facility and she did not think it was necessary to have so many residents with enhanced barrier precautions.On 5/13/26 at 9:20 am the Director of Nursing was interviewed. The DON stated Nurse #14 had discussed with the DON the use of enhanced barrier precautions with PPE for gastrostomy tube access and medication administration for Resident #112. The DON stated Nurse #14 reported to the DON that she had not worn gloves when handling the glucometer with a test strip which had a blood sample and discarded the strip with a tissue. Nurse #14 had not mentioned the use of PPE for gastrostomy tube access. The DON indicated that enhanced barrier precaution signage was present on Resident #112's room door and PPE was available and required to be used to care for and access the gastrostomy tube. The DON stated that Nurse #14 was new to long term care and had received infection control education upon hire. On 5/13/2026 at 12:50 pm an interview was completed with the Medical Director. The Medical Director was informed that Nurse #14 failed to use PPE for enhanced barrier precautions. The Medical Director indicated gloves and enhanced barrier precautions were very important to prevent infection and were required. On 5/14/26 at 12:30 pm an interview was completed with the Infection Preventionist. The Infection Preventionist was informed of Nurse #14's failure to use PPE when accessing Resident #14's gastrostomy tube. The Infection Preventionist stated she would follow up with Nurse #14 and commented that she completed observations for staff's use of PPE regularly. The Infection Preventionist commented that all staff received infection control education, including use of PPE, upon hire and annually. 2. The facility Obtaining a Fingerstick Glucose Level policy dated October 2011 documented in part Equipment and Supplies: 7. Personal protective equipment (e.g. gowns, gloves, mask, etc. as needed). Steps in the Procedure: 5. Wear clean gloves. 11. Place a drop of blood on the strip. 12. Wipe the fingertip with a cotton ball to seal the puncture site. 13. If bleeding persists, apply a bandage. 15. Point the spring-loaded device down and away from the face and body and carefully remove the lancet. Dispose of the lancet in the sharps disposable container. 17. Discard disposable supplies in the designated containers. 18. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. 19. Remove gloves and discard into designated container. 20. Wash hands. On 5/11/26 at 12:30 pm Nurse #14 was observed to exit Resident #75's room holding Resident #75's glucometer with the test strip in place which had a blood sample with her right ungloved hand. Nurse #14 was not wearing any gloves, and she handled the glucometer after the finger stick with a test strip in place. Nurse #14 was observed to remove the test strip from the glucometer using an ungloved hand and tissue and placed the strip into the garbage. Nurse #14 walked to the medication cart with the glucometer in her hand (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and placed it on a piece of paper. Nurse #14 was interviewed at the medication cart and stated she was new to long term care, about 8 days. Nurse #14 stated all residents had their own glucometer with a plastic case to store on the medication cart. Nurse #14 confirmed she had not worn gloves to handle the glucometer with the test strip that had the blood sample and discarded the test strip using a tissue. Nurse #14 indicated she thought using a tissue was an appropriate barrier. On 5/13/26 at 9:20 am the Director of Nursing was interviewed. The DON stated Nurse #14 had discussed with the DON the use of gloves for handling the glucometer with a test strip that had a blood sample and discard of the strip for Resident #75 on 5/12/26. The DON stated Nurse #14 reported to the DON that she had not worn gloves when handling the glucometer with a test strip which had a blood sample and discarded the strip with a tissue. The DON stated that Nurse #14 was new to long term care and had received infection control education and use of PPE upon hire. On 5/14/26 at 12:30 pm an interview was completed with the Infection Preventionist. The Infection Preventionist was informed of Nurse #14's handling of a glucometer with a test strip which had a blood sample without gloves and discarding the strip with a tissue. The Infection Preventionist stated she would follow up with Nurse #14. The Infection Preventionist commented that all staff received infection control education, including obtaining a blood sample for the test strip and management of the resident's glucometer, upon hire and annually. On 5/13/2026 at 12:50 pm an interview was completed with the Medical Director. The Medical Director was informed that Nurse #14 failed to wear gloves to handle the glucometer with test strip with a blood sample. The Medical Director indicated gloves were very important to prevent infection and were required.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations, record reviews, and staff interviews, the facility failed to post an updated daily nurse staffing sheet for residents and visitors on 1 of 4 days during the survey period (5/11/26).Findings included:On 5/11/26 (Monday) at 9:35 AM, during the initial tour, the daily nurse staffing sheet posted near the facility's main entrance was dated 5/8/26 (Friday). The sheet had not been updated to reflect the current date, census, or staffing information.On 5/13/26 at 11:10 AM, during an interview, the Scheduler indicated that she prepared the daily nurse staffing sheets on Fridays and placed them in a folder at the nurses' station for weekend staff to update and post. She noted that she was not on duty on 5/9/26 or 5/10/26 (weekend) and had not realized on the morning of 5/11/26 that the posted sheet still reflected the date of 5/8/26.On 5/13/26 at 11:40 AM, during a phone interview, Nurse #8, indicated that she worked as weekend supervisor the night shift on 5/10/26 and was responsible for updating and posting the staffing sheet. She reported that she updated the sheet on the morning of 5/11/26 but became busy with resident care and did not post it near the main entrance.On 5/13/26 at 12:10 PM, during an interview, the Director of Nursing (DON) indicated that the Scheduler was responsible for completing the daily nurse staffing sheet and posting it on weekdays, while the weekend nurseˆsupervisor was responsible for posting it on weekends. The DON acknowledged that the sheet was not updated on 5/11/26 because the weekend nurseˆsupervisor became busy that morning.