PRINTED: 05/19/2021 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
741012741	or contraction	IDENTIFICATION NOMBER.	A. BUILDING: _			
		FCL046002	B. WING		R 04/28/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CARVER	MANOR		NGTON ROAD SBORO, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
C 000	Initial Comments		C 000			
	_	sure Section conducted an survey on April 28, 2021.				
C 022	10A NCAC 13G .0302 Construction	2 (b) Design And	C 022			
	10A NCAC 13G .0302	2 Design And Construction				
		be planned, constructed, ined to provide the services				
	reviews, the facility fa evacuation capabilitie the evacuation capab current license for 2 c and #3) who had cog physical impairments prompting to exit the	ns, interviews, and record iled to ensure the residents' as were in accordance with ility listed on the facility's of 3 sampled residents (#2 nitive impairments and/or				
	The findings are:					
		s current license effect e facility was licensed for 6				
44.0	8:45am revealed the of 5 residents residing	ministrator on 04/28/21 at facility had a current census g in the facility, with 4 1 resident at the hospital.				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		, ,	E SURVEY PLETED
FCL046002 B. WING 0			R I/28/2021			
				TID CODE] 02	1/20/2021
NAME OF P	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
CARVER	MANOR		SHINGTON ROAD EESBORO, NC 278	55		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 022	Continued From page	e 1	C 022			
	Review of the facility' was no documentatio 01/07/20.	s fire drill log revealed there on of a fire drill since				
	03/16/21 revealed: -Diagnoses included obsessive-compulsive	ermittently disoriented				
	care plan dated 03/08 -The resident was so forgetful, needing ren -The resident require with ambulation, exte	metimes disoriented and ninders. d limited staff assistance ensive staff assistance with and dependent on staff for				
	04/28/21 from 9:25an -The resident was ob in the common areas the facilityThe resident ambula without staff assistan -The resident was ab	served intermittently sitting and on the outside deck of a steed in and out of the facility ce or an assistive device. It is to engage in conversation sponses, however unable to				
	medication aide/persions/204/28/21 between 6:10-At 6:14pm, the MA/F hallway of the facility activating the audible -Resident #2 was sitt side of the common li	e drill conducted by the conal care aide (MA/PCA) on 14pm and 6:16pm revealed: PCA was standing in the and initiated a fire drill by fire alarm. If ing in a chair on the right iving room next to the exit d another resident				

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		FCL046002	B. WING		R 04/28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CARVER	MANOR	208 WASH	INGTON ROAD		
OARTER		MURFREE	SBORO, NC 2	7855	_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 022	Continued From page	2	C 022		
C 022	until, the MA yelled fir At 6:14pm, Resident the 3 other residents At 6:14pm, Resident under the facility's care. Observation of the MA 6:15pm revealed the residents as they wer they did not move who who was a street of the facility and the facility in an emeral existence of the facility and th	or the left side of the coroceed to the exit door the "move it", Come on". #2 exited the facility with through the same exit door. #2 stopped and stood report. A/PCA on 04/28/21 at PCA/MA asked the ere-entering the facility why en the fire alarm sounded. With a nurse with Resident covider on 04/28/21 at eagnosis of dementia and disability. Is dementia, the resident some type of verbal order to safely evacuate gency such as a fire. I follow them during an efacility. With Resident #2's primary is nurse on 04/28/21 at	C 022		
	dementia with an ons				
	-There would be cond				
	_	ntia to evacuate the facilty			
	some type of direction or verbally.	se the resident would need n from staff either physically			
	intellectual disabilities	ncern for a resident with s who might not cognitively going on or the need to exit			

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	DING:	
					R
		FCL046002	B. WING		04/28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		208 WASH	INGTON ROAD		
CARVER	MANOR		SBORO, NC 2		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
C 022	Continued From page	e 3	C 022		
	residents with demen	ohysically or verbally assist			
		ministrator on 04/28/21 at sident #2 required prompting ng fire drills.			
	Refer to interview wit 04/28/21 at 4:56pm.	h the Administrator on			
	03/16/21 revealed: -Diagnoses included unspecified psychosis disorder, and was no -The resident was arr care from staff.	s, unspecified mood			
	care plan dated 03/16 -The resident had dersaw a mental health processed and require eating, and total assistants ambulation, bathing, transferringThe resident was un	velopmental disabilities and provider. ented with significant uired direction. af and non-verbal. d extensive assistance with			
	9:25am revealed:	ent #3 on 04/28/21 at chair in his bedroom. and did not answer			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S COMPLI	
FCL046002		B. WING		R 04/28/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•	
CARVER I	MANOR		HINGTON ROAD			
			ESBORO, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 022	Continued From page	2 4	C 022			
	smiled when spoken interview with the me aide (MA/PCA) on 04 Resident #3 required	dication aide/personal care /28/21 at 9:45am revealed total care in which she had ect him in all activities				
	MA/PCA on 04/28/21 6:16pm revealed: -At 6:14pm, the MA/P hallway of the facility activating the audible -Resident #3 was sitti side of the common li door of the facility and sitting in a chair on the sitting areaResident #3 did not puntil, the MA yelled fir -At 6:14pm, Resident the 3 other residents	CA was standing in the and initiated a fire drill by fire alarm. Ing on the couch on the left ving room next to the exit d another resident was e right side of the common proceed to the exit door e "move it", Come on". #3 exited the facility with through the same exit door. #3 stopped and stood				
	6:15pm revealed the residents as they wer they did not move wh Interview with the me aide (MA/PCA) on 04 Resident #3 required	e re-entering the facility why en the fire alarm sounded. dication aide/personal care /28/21 at 9:45am revealed total care in which she had ect him in all activities				

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Telephone interview with Resident #3's mental

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DIVISION	n Health Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
					_	
			D WING		R	
		FCL046002	B. WING		04/2	8/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE. ZIP CODE		
			INGTON ROAL	,		
CARVER I	MANOR					
		MURFREE	SBORO, NC 2	.7855		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	JAIL	DATE
				,		
C 022	Continued From page	e 5	C 022			
		04/00/04 1 0 45				
		se on 04/28/21 at 2:15pm				
	revealed:					
	-Resident #3 had a di					
	retardation and deme	•				
	assistance, direction,	and prompting.				
	-Resident #3 could no	ot make safe decisions for				
	himself independently	/.				
	-If there was a fire, sh	ne did not feel that Resident				
	#3 would be able to p	rocess the need evacuate				
	independently.					
	, ,					
	Telephone interview v	vith Resident #3's primary				
	care provider's (PCP)					
	-Resident #3 had diag					
		s, and was non-verbal.				
		p and direction in the event				
	•					
	of an emergency for r	esiderii sarety.				
	linda mai avva vaidle dle a Ala	ini-tratar an 04/20/24 at				
		ministrator on 04/28/21 at				
		ident #3 required prompting				
	to exit the facility duri	ng fire drills.				
		h the Administrator on				
	04/28/21 at 4:56pm.					
		ministrator on 04/28/21 at				
	4:56pm revealed:					
		ty and was the only staff				
		ght and on days that the				
	•	onal care aide (MA/PCA)				
	staff member was off	duty.				
	-The MA/PCA staffed	the facility from 7:30am to				
	5:00pm with a 1-hour	lunch each shift and worked				
	a rotating schedule of	f 4 days on and then 4 days				
	off.	•				
		staff members that worked				
	at the facility.	12-12 - 1 - 2 - 1 - 2				
	<u>-</u>	stayed the night unless she				
	was needed and aske					

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-She had regular quarterly fire drills with the

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:		R
		FCL046002	B. WING		04/28/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
CARVER I	WANOR		HINGTON ROAD		
071110 2111			ESBORO, NC 2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
C 022	Continued From page	e 6	C 022		
	the residents there was facilityShe would make sur exit the facility during -She stated, "I don't k	ennounced, in which she told as a fire and to get out of the e all residents were able to the fire drills. Inow what I would do if we led not hear it (fire alarm)".			
	equipped and mainta living in the facility wh deficits to evacuate in emergency such as a	ined to allow 2 of 3 residents no had physical and cognitive independently in case of an ifire. The facility's failure health, safety, and welfare constitutes a Type B			
	in accordance with G	vas submitted by the facility .S. 131D-34 on 04/28/21 05/04/21. The Plan of			
	CORRECTION DATE VIOLATION SHALL N 2021.	FOR THE TYPE B NOT EXCEED JUNE 12,			
C 069	10A NCAC 13G .0312 Exits	2(g) Outside Entrance And	C 069		
	Exits (g) In homes with at determined by a physic be disoriented or a for resident use shall sounding device that opened. The sound so that it can be heard be	least one resident who is sician or is otherwise known wanderer, each exit door be equipped with a is activated when the door is shall be of sufficient volume y staff. If a central system evices is provided, the			

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R
NAME OF PROVIDER OR SUPPLIER CARVER MANOR 208 WASHINGTON ROAD MURFREESBOO, No. 27855 (X4) ID SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE TAG CONTINUED From page 7 COntrol panel for the system shall be located in the bedroom of the person on call, the office area or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 exit doors had an audible alarm that was on at all times and at a sufficient volume for staff to hear once activated for 2 of 3 residents sampled who were diagnosed with dementia (#2, #3). The findings are: Observations upon entrance to the facility on 04/28/21 at 8:47am and intermittently throughout the day until 7:00pm revealed: -The facility's side exit door was the main door used by staff and residents. -There was no audible alarm when the side exit door to the facility was opened. Observation of the facility's front exit door of the facility on 04/28/21 at 9:00am revealed there was no sounding alarm device when the door to the facility was opened.
MURFREESBORO, NC 27855 (K4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DATE) C 069 C 069 C 069 C 069 Continued From page 7 control panel for the system shall be located in the bedroom of the person on call, the office area or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 exit doors had an audible alarm that was on at all times and at a sufficient volume for staff to hear once activated for 2 of 3 residents sampled who were diagnosed with dementia (#2, #3). The findings are: Observations upon entrance to the facility on 04/28/21 at 8.47am and intermittently throughout the day until 7:00pm revealed: -The facility's side exit door was the main door used by staff and residents. -There was no audible alarm when the side exit door to the facility was opened. Observation of the facility's front exit door of the facility on 04/28/21 at 9:00am revealed there was no sounding alarm device when the door to the facility was opened.
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) C 069 Continued From page 7 control panel for the system shall be located in the bedroom of the person on call, the office area or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 exit doors had an audible alarm that was on at all times and at a sufficient volume for staff to hear once activated for 2 of 3 residents sampled who were diagnosed with dementia (#2, #3). The findings are: Observations upon entrance to the facility on 04/28/21 at 8-47am and intermittently throughout the day until 7:00pm revealed: -The facility's side exit door was the main door used by staff and residents. -There was no audible alarm when the side exit door to the facility was opened. Observation of the facility's front exit door of the facility on 04/28/21 at 3-00am revealed there was no sounding alarm device when the door to the facility was opened.
control panel for the system shall be located in the bedroom of the person on call, the office area or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 exit doors had an audible alarm that was on at all times and at a sufficient volume for staff to hear once activated for 2 of 3 residents sampled who were diagnosed with dementia (#2, #3). The findings are: Observations upon entrance to the facility on 04/28/21 at 8:47am and intermittently throughout the day until 7:00pm revealed: -The facility's side exit door was the main door used by staff and residents. -There was no audible alarm when the side exit door to the facility was opened. Observation of the facility's front exit door of the facility on 04/28/21 at 9:00am revealed there was no sounding alarm device when the door to the facility was opened.
Interview with the medication aide/personal care aide (MA/PCA) on 04/28/21 at 9:47am revealed the facility did not have audible alarms at the two exit doors. Interview with the Administrator on 04/28/21 at 5:30pm revealed: -The facility had door alarms on all exit doors alerting which door was opened. -The alarm's sounding device was located in her living area and sleeping quarters. -The alarm was turned off during the day and

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED
						R
		FCL046002	B. WING		04	/28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CARVER	MANOR	208 WAS	SHINGTON ROAD			
		MURFRE	EESBORO, NC 278	55		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 069	Continued From page	e 8	C 069			
	turned on at night.					
	located in the Adminis sleeping quarters revidoor was opened, the the side door was openot be heard outside area and sleeping quit. Review of Residen 03/16/21 revealed: -Diagnoses included obsessive-compulsive-The resident was interested to the resident was arrested to the resident was a resi	t #2's current FL-2 dated diabetes, hypertension and e disease. ermittently disoriented.				
	04/28/21 from 9:25an -The resident was ob in the common areas the facilityThe resident ambula without staff assistant -The resident was ab	served intermittently sitting and on the outside deck of ted in and out of the facility ce or an assistive device. le to engage in conversation sponses, however unable to				
	#2's mental health pro 2:30pm revealed it wa	as important to have a ert staff when Resident #2 due to the resident's a in order to keep the				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
FCL046002		B. WING		R 04/28/2021		
NAME OF D	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZID CODE	1 04/2	.0/2021
NAIVIE OF P	ROVIDER OR SUPPLIER		IINGTON ROAL			
CARVER	MANOR		SBORO, NC 2			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETE DATE
C 069	Continued From page	9	C 069			
	care provider's (PCP' 3:19pm revealed: -The resident had a d -The facility should ha and in working order the resident's supervi Refer to the interview 04/28/21 at 5:30pm. 2. Review of Residen 03/16/21 revealed: -Diagnoses included unspecified psychosis disorder, was non-vel and bowelThe resident was am care from staff.	ave alarms on all exit doors 24 hours per day to aid in sion. with the Administrator on t #3's current FL-2 dated mental retardation,				
	care plan dated 03/16 -The resident had devisaw a mental health p -The resident was orionemory loss and requirements and requirementsThe resident requirements and total assistance.	velopmental disabilities and provider. ented with significant uired direction. af and non-verbal. d extensive assistance with				
	9:25am revealed:	ent #3 on 04/28/21 at chair in his bedroom. ind did not answer				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		'	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or dortheorion	A. BUILDING:			
FCL046002			B. WING		R 04/28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
CARVER	MANOR	208 WASH	IINGTON ROAD)	
		MURFREE	SBORO, NC 2	7855	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
C 069	Continued From page	e 10	C 069		
		t, nodded his head, and			
	aide (MA/PCA) on 04 Resident #3 required	dication aide/personal care /28/21 at 9:45am revealed total care in which she had ect him in all activities do it for himself.			
	health provider's nurs revealed: -Resident #3 had a di could contribute to the wandering or eloping. -The resident was und for himself and require -The facility should ha	able to make safe decisions ed 24/7 supervision.			
	care provider's (PCP) 3:19pm revealed the on all exit doors and i per day to aid in the retresident's confusive eloping, or wandering	away.			
	Refer to the interview 04/28/21 at 5:30pm.	with the Administrator on			
	5:30pm revealed: -There had been no refacility without staffs' -The central alarm syscould not be heard the exit door was opened	stem in her living quarters roughout the facility when an			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		FCL046002	B. WING		04/28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CARVER I	MANOR		INGTON ROAD		
			SBORO, NC 2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 069	Continued From page	: 11	C 069		
	-She was planning to both exit doors and m her living quarters to	the layout of the facility. install an audible alarm on love the central system in a location in the facility in rm to be heard throughout kit door was opened.			
C 191	10A NCAC 13G .060 ⁻ Staff	(d) Management and Other	C 191		
	Staff (d) Additional staff sh	Management and Other hall be employed as needed the supervision and care of			
	This Rule is not met TYPE A2 VIOLATION				
	facility failed to ensur- duty and awake at all supervision needs for who had a diagnosis significant memory lo	and record reviews, the e sufficient staff were on times to meet the 2 of 4 residents (#2 and #3) of dementia (#2) and with as requiring redirection and ance with activities of daily			
	The findings are:				
	_	s current license effective e facility was licensed for 6			
	8:45am revealed: -The facility had a cur	rinistrator on 04/28/21 at rent census of 5 residents with 4 residents on-site and ital.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL046002	B. WING	B. WING		R 8/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA INGTON ROAD SBORO, NC 2)	, , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 191	medication aide/persor-She oversaw the resident was an aide/persor-She oversaw the resident was an aide (MA/PCA) on 04-Resident #2 was incontinent briefs.	cluded herself and one other conal care aide (MA/PCA). idents care when the sent and lived and slept at t. I/PCA on 04/28/21 at 9:45am g schedule of 4 days on and (:30am, ended at 5:00pm, cour for lunch each shift. everything" the care for the vorked. It #2's current FL-2 dated diabetes, hypertension and edisease. ermittently disoriented. abulatory. 2's current assessment and 3/21 revealed: metimes disoriented and ninders. dilimited staff assistance misve staff assistance with , and dependent on staff for dication aide/personal care /28/21 at 9:47pm revealed: distaff assistance with coming, toileting and	C 191			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		
		FCL046002	B. WING		R 04/28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
CARVER	MANOR		INGTON ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
C 191	Continued From page	e 13	C 191		
	Interview with Reside revealed if she neede	ent #2 on 04/28/21 at 9:25am ed anything at night when would call them on the			
	5:18pm revealed: -There was a remova button in the center, puthe resident's bedIn the center of the respeaker symbol over -When the button on the small light did not was observed.	ent #2's room on 04/28/21 at ble round disc with a push positioned on the wall beside ound disc, there was a the button. the round disc was pressed illuminate and no sound ell observed in the resident's			
	at 5:25pm revealed: -The round disc was to needed helpShe never had to use	ith Resident #2 on 04/28/21 for emergencies if she e the round disc for an a staff for help at night.			
	5:29pm revealed: -When Resident #2 p round disc an audible sleeping quarters to a needed helpShe would check in h of Resident #2's alarr Observation from the Administrator's sleepi 5:30pm revealed ther A second interview wi	· ·			

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	A. BUILDING:	
		FCL046002	B. WING		R 04/28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	E, ZIP CODE	
		208 WAS	HINGTON ROAD		
CARVER	MANOR	MURFRE	ESBORO, NC 27	855	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
C 191	quarters when Reside a cord was possibly of a cord was possibly of Telephone interview w#2's mental health pro 2:30pm revealed Res supervision with awal resident due to her di to keep the resident so Telephone interview we care provider's (PCP' at 3:28pm revealed: -The resident had a diding the times because anythis were asleep such as elopement. Refer to the interview 04/28/21 at 10:00am 2. Review of Residen 03/16/21 revealed: -Diagnoses included unspecified psychosis disorder, was non-veil and bowel. -The resident was am care.	ent #2's alarm was pressed; lisconnected. with a nurse with Resident poider on 04/28/21 at ident #2 needed 24 hour was staff to monitor the agnosis of dementia in order rafe. with Resident #2's primary s) nurse office on 04/28/21 diagnosis of dementia. ware that Resident #2 was staff at the facility slept at dequire awake staff at all ng could happen when staff falls, wandering or with the Administrator on and 4:56pm. t #3's current FL-2 dated mental retardation,	C 191		
	care plan dated 03/16	3's current assessment and 5/21 revealed: velopmental disabilities and			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		FCL046002	B. WING		R 04/28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	FE, ZIP CODE	
CARVER	MANOR	208 WAS	SHINGTON ROAD	1	
		MURFRE	EESBORO, NC 27	7855	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
C 191	Continued From page	: 15	C 191		
	saw a mental health particle of the resident was originated in the resident was determined as a month of the resident required eating, and total assist ambulation, bathing, of transferring. Observation of Resident set in a set of the resident set of the resi	provider. ented with significant uired direction. af and non-verbal. d extensive assistance with stance with toileting, dressing, grooming and ent #3 on 04/28/21 at chair in his bedroom. nd did not answer t, nodded his head, and			
	aide (MA/PCA) on 04	/28/21 at 9:45am revealed total care in which she had ect him in all activities			
	health provider's nurs revealed: -Resident #3 had mer assistance, direction and assistance, direction and assistance, direction are resident #3 required day with staff who we resident #3 was una himselfShe did not think Resuse a call bell or call tit. Telephone interview with the revealed to the resident #3 was una himself.	I supervision 24 hours per re awake, not asleep. able to make decisions for sident #3 would be able to for help at night if he needed with Resident #3's primary s) nurse on 04/28/21 at			

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
						R
		FCL046002	B. WING		04/	28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CADVED.	MANOR	208 WASI	HINGTON ROAD			
CARVER	MANUR	MURFRE	ESBORO, NC 2	7855		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	IE APPROPRIATE	COMPLETE DATE
			+	BETTGIENCT	,	
C 191	Continued From page	e 16	C 191			
	retardation psychosis	s, and was non-verbal.				
		nave someone awake to				
	supervise him 24 hou					
	-	vare that Resident #3 was				
		taff at the facility slept at				
	night.	•				
	-The resident could fa	all, elope, wander off, or				
	become confused wh	ile being unsupervised.				
		with the Administrator on				
	04/28/21 at 10:00am	and 4:56pm.				
	Interview with the Adr	 ministrator on 04/28/21 at				
	10:00am and 4:56pm					
	-The medication aide					
		ed the night unless asked;				
	when needed.	-				
	-She had her own livi facility.	ng quarters within the				
	1	per and could hear if the				
	residents got up or m					
	-The facility had exit of	door alarms that were turned				
	off during the day and					
		ting out behavior and had				
	stood over another re	esident's bed while he slept;				
		esidents outside of the				
		cked doorways preventing				
	residents from passin	lg through. lents would call out if they				
	needed anything.	ents would call out it triey				
		halls 3 times per night to				
	check on the resident					
	provided).	(-F				
	· '	call bells at their bedside that				
	would ring in her bed					
	-She was unaware av	vake staff were needed 24				
	hours per day due to	the residents' diagnosis and				
	ability.					
	D (, T	404 1104 0 400 5555				
	Refer to Tag C 0022,	10A NCAC 13G .0302				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
			A. BUILDING		D D
		FCL046002	B. WING		R 04/28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CARVER	MANOR		IINGTON ROAD		
			SBORO, NC 2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 191	Continued From page	e 17	C 191		
	Design and Construc	tion			
		ave awake staff on duty and			
		meet the supervision needs ementia diagnosis (#2) and			
		evelopmentally disabled,			
	_	ntia and unable to care for			
	himself or activate he during the time period	lp if he had any needs			
		cility's failure resulted in			
		rious injury or death to the			
	residents and constitu	ites a Type A2 Violation.			
	The facility was provi	ded a plan of protection in			
		131D-34 on 04/28/21 for			
	on 05/07/21.	addendum on 05/04/21 and			
	CORRECTION DATE VIOLATION SHALL N	FOR THE TYPE A2 IOT EXCEED MAY 28, 2021			
C 281	10A NCAC 13G .0904 Service	4(e)(1) Nutrition and Food	C 281		
		4 Nutrition and Food Service			
		in Family Care Homes: t orders including thickened			
		ing from the resident's			
		licable, the therapeutic diet			
	order shall be specific	c to calorie, gram or for calorie controlled ADA			
	_	is or thickened liquids,			
	unless there are writt	ten orders which include the			
	_	peutic diet identified in the			
	facility's therapeutic n registered dietitian.	ienu approveu by a			
		.,			
	This Rule is not met Based on observation	as evidenced by: n, interviews, and record			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
			A. BUILDING:			
		FCL046002	B. WING		R 04/28/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
CARVER	MANOR	208 WAS	HINGTON ROAD			
CARVER	WANOR	MURFRE	ESBORO, NC 278	355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE COMPLETE	
C 281	Continued From page	e 18	C 281			
		iled to obtain a current diet he primary care provider for ents (# 2).				
	The findings are:					
	03/16/21 revealed: -Diagnoses included obsessive-compulsive-The resident was into	2's current FL-2 dated diabetes, hypertension and e disease. ermittently disoriented. der listed on the FL-2.				
	Review of Resident # dated 05/06/20 revea	2's previous diet orders led a diabetic diet.				
	care plan dated 03/08 -The resident was so forgetful and needed -The resident was on	metimes disoriented and reminders.				
	posted on the door of	evealed: / menu plan for "April"				
	revealed: -She was not sure if s -She received three n -Snacks consisted of Interview with the me	nt #2 on 04/28/21 at 9:25am she was on a special diet. neals a day with snacks. ice cream and cookies. dication aide/personal care /28/21 at 9:47am and at				
	6:54pm revealed:	ng at the facility were not on				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		FCL046002	B. WING		04	R / 28/2021	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	1 0-	72072021	
CARVER	MANOD		HINGTON ROAD				
CARVER	WANUR	MURFRE	ESBORO, NC 278	355			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
C 281	Continued From page	e 19	C 281				
	a therapeutic dietResidents at the faci	lity were on a regular diet. to food when she prepared					
	care provider's (PCP' 3:28pm revealed: -The resident was a cell the FL-2 did not re Resident #2 the facili responsible to clarify resident should be or lt was expected for torders were impleme	flect a current diet order for ty would have been what type of the diet the					
	10:10am and at 6:54ppAll residents were or -The facility did not hat that planned and revious -She was not aware for the state of th						
C 315	10A NCAC 13G .100	2(a) Medication Orders	C 315				
	the resident's physicial for verification or clar medications and treat (1) if orders for admission or readr of admission or readr (2) if orders are not c	ne shall ensure contact with an or prescribing practitioner ification of orders for tments: ssion or readmission of the d and signed within 24 hours mission to the facility;					

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			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		:D
					R	
		FCL046002	B. WING		04/28/2	2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE		
NAME OF T	TOVIDER OR SOLT LIER		INGTON ROAD			
CARVER	MANOR		SBORO, NC 2			
240.15	CLIMMADY CT		1			2/5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE ((X5) COMPLETE DATE
C 315	Continued From page	2 20	C 315			
	admission or readmis forms are not the sam The facility shall ensu	sion and orders on the				
	review, the facility fail medications was obta of two topical medicat	n, interview and record ed to ensure clarification of ained prior to administration tions used for inflamed skin skin infections for 1 of 3				
	The findings are:					
	03/16/21 revealed: -Diagnoses included obsessive-compulsive	ermittently disoriented.				
	care plan dated 03/08	metimes disoriented and reminders. /as "VERY DRY".				
	revealed: -She received all med -She was not sure wh	nat kind of medications she ications were prescribed for.				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	SURVEY PLETED
			B. WING			R
		FCL046002	B. WING		04	/28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
CARVER	MANOR		HINGTON ROAD			
	T	MURFREI	ESBORO, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 315	Continued From page	21	C 315			
	a. Review of Residen 03/16/21 revealed the Desonide 0.05% lotio	t #2's current FL-2 dated ere was an order for in twice daily. (Desonide dication used to treat a ons including eczema,				
		2's previous FL-2 dated order for Desonide 0.05%				
	hand on 04/28/21 at 1 -Desonide 0.05% lotic skin with a dispensed	on topical as needed for dry date of 06/03/20. Ited instructions where to				
	2021 and April 2021 r record (MAR) reveale -There was an entry f lotion apply twice dail administration of 8:00 -There was document 0.05% lotion had been	or Densonside [sic] 0.05% y with a scheduled				
	aide (MA/PCA) on 04	dication aide/personal care /28/21 at 10:35am revealed applied to Resident #2's y, red skin areas.				
	contracted pharmacy 2:47pm revealed: -Desonide 0.05% was treat inflammation of t been ordered for a ras	nacist with the facility's provider on 04/28/21 at s a topical steroid used to the skin and could have sh.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. DUILDING: _		
		FCL046002	B. WING		R 04/28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
CARVER	MANOR		INGTON ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
C 315	to apply Resident #2's medication to be adm primary care provider Telephone interview on urse on 04/28/21 on -Resident #2 saw the physical exam section an entry the resident faceThere was no indicat #2's Desonide 0.05% -She assumed Desor applied to Resident # that was noted on exasureIt would have been in the facility to have co to clarify where Deso been applied prior to medication. Refer to the interview 04/28/21 at 10:35am. b. Review of Residen 03/16/21 revealed the Ketoconazole 2% loti (Ketoconazole 2% loti (Ketoconazole 2% loti used to treat fungal s Review of Resident # 03/19/20 revealed an lotion twice daily. Observation of Residhand on 04/28/21 at 25	s Desonide 0.05% for the inistered as ordered by the (PCP). with Resident #2's PCP's 3:28pm revealed: PCP on 02/02/21 and in the of the visit note there was had dry skin noted on her tion where to apply Resident and expected for noted that and expected for noted Resident #2's PCP noted 0.05% should have the administration of the with the Administrator on the was an order for on twice daily. It is a topical medication kin infections). 2's previous FL-2 dated order for Ketoconazole 2% ent #2's medications on	C 315	DETICIENCY)	
	fungal rash with a dis	pensed date of 04/06/21. ated instructions where to			

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	ND PLAN OF CORRECTION IDENTIFICATION NUMBER		' '	(X2) MULTIPLE CONSTRUCTION (X:		
			A. BUILDING:	A. BUILDING:		PLETED
		FCL046002	B. WING		04	R //28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
045)/55		208 WAS	HINGTON ROAD			
CARVER	MANOR	MURFRE	ESBORO, NC 278	55		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 315	Continued From page	e 23	C 315			
	apply Ketoconazole 2	19/ twigo doily or the				
		resident's fungal rash.				
	2021 and April 2021 record (MAR) reveale -There was an entry f apply twice daily with of 8:00am and 8:00pr -There was documen cream had been adm 02/01/21 - 04/28/21 a Interview with the me aide (MA/PCA) on 04 Ketoconazole 2% wa scalp or any other dry	or Ketoconazole 2% cream a scheduled administration m. tation Ketoconazole 2% inistered twice daily from t 8:00am and 8:00pm. dication aide/personal care //28/21 at 10:35am revealed s applied to Resident #2's y, scaly, red skin areas. with a pharmacist with the harmacy provider on				
	-Ketoconazole 2% wa	as a topical medication used				
	to use the topical med #2's ordered Ketocon different areas of the	ons. ave clear instructions where dication to ensure Resident azole was not placed in skin at the same time to any type of fungal skin				
	care provider's (PCP' 3:28pm revealed: -Resident #2's order thave specific instruction medication should hather would review the provide any additional -There would have be	ve been applied. e resident's record and				

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				(X3) DATE SURVEY COMPLETED	
	FCL046002	B. WING		R 04/28/2021	
VIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ANOR	208 WAS	SHINGTON ROAD			
	MURFR	EESBORO, NC 278	55		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
Continued From page	24	C 315			
	•				
vas no additional info	rmation provided by				
Refer to the interview 04/28/21 at 10:35am.	with the Administrator on				
10:35am revealed: Resident #2 had occaner body including dry different areas. The medication was por any dry skin areas various areas including underneath the reside She would contact Reprovider (PCP) for clappical medications or She was aware resident order from the PCF administration with sprowever she had never the provider occane.	asional areas to develop on a reasional areas to develop on a reaside rescribed for Resident #2 and could be applied to g the resident's buttocks, ant's breast, head or face. The esident #2's primary care rification regarding the dered. The ents' medications required be indicating the route of ecific instructions of use, er thought about topical				
Administration 10A NCAC 13G .1004 a) A family care homoreparation and adminorescription and non-poy staff are in accordant	Medication Administration le shall assure that the histration of medications, brescription and treatments her with: led prescribing practitioner	C 330			
	continued From page of where to apply Kete dministration of the r at the time of exit on the resident #2's PCP's r defer to the interview 4/28/21 at 10:35am. Atterview with the Adn 0:35am revealed: Resident #2 had occa er body including dry ifferent areas. The medication was per any dry skin areas arious areas includin nderneath the reside She would contact Re rovider (PCP) for cla opical medications or She was aware resid n order from the PCF dministration with sp owever she had never reams requiring this OA NCAC 13G .1004 administration OA NCAC 13G .1004 administration OA NCAC 13G .1004 administration and admir rescription and non-p y staff are in accorda 1) orders by a license which are maintained	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 24 If where to apply Ketoconazole 2% prior the dministration of the medication. If the time of exit on 04/28/21 at 7:30pm there was no additional information provided by desident #2's PCP's nurse. Refer to the interview with the Administrator on 4/28/21 at 10:35am. Interview with the Administrator on 04/28/21 at 0:35am revealed: Resident #2 had occasional areas to develop on er body including dry, red skin occurring in ifferent areas. The medication was prescribed for Resident #2 or any dry skin areas and could be applied to arious areas including the resident's buttocks, nderneath the resident's breast, head or face. She would contact Resident #2's primary care rovider (PCP) for clarification regarding the opical medications ordered. She was aware residents' medications required norder from the PCP indicating the route of dministration with specific instructions of use, owever she had never thought about topical reams requiring this information. OA NCAC 13G .1004(a) Medication	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 24 f where to apply Ketoconazole 2% prior the dministration of the medication. At the time of exit on 04/28/21 at 7:30pm there was no additional information provided by desident #2's PCP's nurse. Refer to the interview with the Administrator on 44/28/21 at 10:35am. Interview with the Administrator on 04/28/21 at 0:35am revealed: Resident #2 had occasional areas to develop on er body including dry, red skin occurring in ifferent areas. The medication was prescribed for Resident #2 or any dry skin areas and could be applied to arious areas including the resident's buttocks, nderneath the resident's breast, head or face. She would contact Resident #2's primary care rovider (PCP) for clarification regarding the opical medications ordered. She was aware residents' medications required norder from the PCP indicating the route of dministration with specific instructions of use, owever she had never thought about topical reams requiring this information. OA NCAC 13G .1004(a) Medication dministration OA NCAC 13G .1004 Medication Administration and A family care home shall assure that the reparation and administration of medications, rescription and non-prescription and treatments y staff are in accordance with: 1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and	MURFREESBORO, NC 27855 SUMMARY STATEMENT OF DEFICIENCISE SUMMARY STATEMENT OF DEFICIENCISE (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) DPRETIX TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY DEFICIENCY	

Division of Health Service Regulation

STATE FORM 6899 IMJU11 If continuation sheet 25 of 51

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
VIAD LEWIN (DI GOMMEDITON	IDENTIFICATION NUMBER.	A. BUILDING:		COIVII LETED	
		FCL046002	B. WING		R 04/28/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CARVER	MANOR	208 WASH	INGTON ROAD)		
OAKVEK	WARTOR	MURFREE	SBORO, NC 2	7855		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLET	E
C 330	Continued From page 25		C 330			
	and procedures.					
	·					
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	were administered ac prescribed by the resi (PCP) for 2 of 3 samp	illed to ensure medications cording to orders as idents' primary care provider oled residents (#3, #2) ed medication for anxiety				
	The findings are:					
	The findings are: Review of the facility's medication policy and procedure manual revealed: -There was a table of contents for the policy and procedure manual. -There was an "Administration of Medications" policy listed in the table of contents, however, the policy was not stored in the manual.					
	4:59pm revealed: -She was unable to lo Medications" policy.	ministrator on 04/28/21 at ocate the "Administration of olocate the policy and review.				
		of Medications" policy was he survey exit on 04/28/21.				
	Review of Residen 03/16/21 revealed: -Diagnoses included unspecified psychosis disorder. -The resident was not	s, unspecified mood				

Division of Health Service Regulation

STATE FORM 6899 IMJU11 If continuation sheet 26 of 51

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	FCL046002	B. WING	B. WING		3/2021
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 0-1/20	7/2021
CARVER MANOR		INGTON ROAD SBORO, NC 2			
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
hours, PRN (as need (Ativan is commonly insomnia due to strest-There was no docum resident's behavior. Review of Resident # 01/04/21 revealed: -Diagnoses included unspecified psychosidisorderThe resident was noter hours, PRN (as need Review of Resident # care plan dated 03/10 could not speak, the wrong with the resident sat in a series of the was non-verbal a questionsHe did make eye cosmiled when spoken Review of Resident # administration record revealed: -There was an entry every 8 hours PRN for Ativan 0.5mg, 1 table administered every details of the common the condition of the conditi	for Ativan 0.5mg, every 8 led) for agitation/anxiety. used to treat anxiety or ss.) nentation regarding the #3's previous FL-2 dated mental retardation, s, unspecified mood on-verbal. for Ativan 0.5mg, every 8 led) for agitation/anxiety. #3's current assessment and 6/21 revealed the resident staff "guessed" at what was ent or what may be hurting. dent #3 on 04/28/21 at a chair in his bedroom. and did not answer intact, nodded his head, and to.	C 330			

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STATE FORM 6899 IMJU11 If continuation sheet 27 of 51

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION		E SURVEY PLETED	
						R
		FCL046002	B. WING		04	1/28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CARVER	MANOR		SHINGTON ROAD			
OARVER		MURFRE	EESBORO, NC 278	55		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 330	Continued From pag	e 27	C 330			
	revealed: -There was an entry every 8 hours PRN f -Ativan 0.5mg, 1 tab administered every c -There was no docur medication was adm effectiveness. Review of Resident a 2021 revealed: -There was an entry every 8 hours PRN f -Ativan 0.5mg, 1 tab administered every c -There was no docur	for Ativan 0.5mg, one tablet or agitation or anxiety. let, was documented as day at 8:00am and 8:00pm. mentation reflecting why the inistered or follow-up for #3's MAR dated February for Ativan 0.5mg, one tablet or agitation or anxiety. let, was documented as day at 8:00am and 8:00pm. mentation reflecting why the inistered or follow-up for				
	dated 03/16/21 rever recommendation not and to only administr	#3's pharmacy drug review aled there was a to give PRN drugs routinely er the medication when fic condition in which it was				
	health provider's nur revealed: -The resident was la provider on 02/10/21 evaluated every 6 m -Resident #3's Atival to be administered a anxietyIf the resident's mod resident should "hard medication.	n medication was prescribed s needed for agitation or od remained stable, the				

Division of Health Service Regulation

STATE FORM 6899 IMJU11 If continuation sheet 28 of 51

DIVISION	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			D WING		R	
		FCL046002	B. WING		04/28/2021	
NAME OF D	ROVIDER OR SUPPLIER	STDEET AF	DRESS, CITY, STA	TE ZIR CODE		
NAME OF T	NOVIDEN ON SOIT LIEN					
CARVER I	MANOR		HINGTON ROAL			
		MURFRE	ESBORO, NC 2	7855		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE	
				DEFICIENCY)		
C 330	Continued From page	28	C 330			
0 000	Continued From page	5 20	0 000			
	on 02/10/21 that the r	esident's mood was fine,				
	and that the resident	ate, slept, and behaved well				
		assessment of Resident #3				
	indicating we would ra					
		ovider did not know that the				
		ministered Ativan 0.5mg				
	twice daily on a sched					
	_					
		erned that the facility staff				
	were trying to keep th	•				
		es medication, such as				
		ninistered as ordered.				
		not be administered Ativan				
		behavior issues such as				
	agitation or anxiety, w					
	admnistration of the n	nedication per the order.				
	-If the resident had ar	ny behavior issues reported				
	by the facility or obse	rved by his provider, it would				
		ed by the mental health				
	provider.	- a - a - a - a - a - a - a - a - a - a				
	providor.					
	Telenhone interview v	with the facility's contracted				
		21 at 2:47pm revealed:				
	•	•				
		ers dated 04/15/21, 03/1/21,				
		1 for Ativan 0.5mg every 8				
	hours as needed for a	,				
		tion typically used to calm				
	and help relax.					
		Ativan to be administered				
		ıld only be given as needed.				
		stered to Resident #3 when				
	not needed, it could o					
	dependence of the m	edication, as well as				
	increase the residence	e's tolerance to the				
	medication requiring	a higher dose in the future to				
	be effective for treatm	_				
	Interview with the Adr	ministrator on 04/28/21 at				
	5:36pm revealed:					
		et and "you would never				
	-nesident#3 was qui	ecand you would nevel	1		1	

Division of Health Service Regulation

know he was in the house".

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Division	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
			B WING		R	
		FCL046002	B. WING		04/28	3/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
CARVER I	MANOR		INGTON ROAD			
		MURFREE	SBORO, NC 2	7855		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	THE COLUMN TOTAL	100 IDENTIFICATION OF THE OF T	TAG	DEFICIENCY)		
C 330	Continued From page 29		C 330			
	D : 1 (//0 !: 1 ()					
	** *	nave behavior outbursts or				
	confusion but would s					
		ould not communicate.				
	** *	llow commands and would				
		cate with sign language.				
		d Resident #3's Ativan				
		on for anxiety or agitation as				
	a scheduled medication, twice per day at 8:00am and 8:00pm, for at least 4 years.					
		ss in place to ensure follow				
	up of pharmacy review					
		vas unaware that his Ativan				
	0.5mg PRN medication					
	scheduled instead of					
	-She felt that Residen					
		Ativan 0.5mg assisted in				
	keeping the resident					
		ssed the Ativan PRN order				
		nis PCP to have the order				
	clarified or updated to					
	administration practic					
		y she had never discussed				
		Ativan for Resident #3 with				
	his PCP.					
	Refer to the interview	with the Administrator on				
	04/28/21 at 4:59pm.					
		t #2's current FL-2 dated				
	03/16/21 revealed:					
		diabetes, hypertension and				
	obsessive-compulsive					
		ermittently disoriented.				
	-There was an order f	for Klor-Con 10meq daily.				
	(Klor-Con is used to t	reat or prevent low				
	potassium levels).					
	•					
	Review of Resident #	2's previous FL-2 dated				

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Klor-Con 10meq daily.

03/19/20 revealed there was an order for

STATE FORM 6899 IMJU11 If continuation sheet 30 of 51

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILDING.	A. BUILDING:	
		FCL046002	B. WING		R 04/28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CARVER MANOR			HINGTON ROAD ESBORO, NC 2		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT	TION (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETE
C 330	30 Continued From page 30		C 330		
	review dated 02/24/2 be obtained and adm primary care provider Review of Resident # medication administra -There was an entry f with a scheduled adm -Klor-Con 10meq was administered daily at 01/31/21. Review of Resident # revealed: -There was an entry f with a scheduled adm -Klor-Con 10meq was	2's January 2021 ation record (MAR) revealed: for Klor-Con 10meq daily ninistration time of 8:00am s documented as 8:00am from 01/01/21 - 2's February 2021 MAR for Klor-Con 10meq daily ninistration time of 8:00am			
	revealed: -There was an entry f with a scheduled adm -Klor-Con 10meq was administered daily at 03/31/21. Review of Resident # revealed: -There was an entry f with a scheduled adm -Klor-Con 10meq was	8:00am from 03/01/21 - 2's April 2021 MAR for Klor-Con 10meq daily ninistration time of 8:00am			
	Interview with Reside revealed:	nt #2 on 04/28/21 at 9:25am			

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	of Health Service Regu					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R	
		FCL046002	B. WING		04/28/2021	
		0.70.55.1		FF 710 000F	•	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT			
CARVER I	MANOR		SHINGTON ROAD			
		MURFRE	ESBORO, NC 27	7855		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	l l	
		,		DEFICIENCY)		
C 330	Continued From Bone	- 24	C 330			
C 330	Continued From page 31		0 330			
	-She received all med	dications from staff.				
		nat kind of medications she				
	took or what the med	ication were prescribed for.				
		5				
	•	with a Pharmacist at the				
		harmacy on 04/28/21 at				
	2:47pm revealed:	dispensed on 04/05/21 with				
	-Klor-con 10meq was dispensed on 04/05/21 with a quantity of 30 tablets.					
		s dispensed on 03/08/21				
	with a quantity of 30 t	•				
		s dispensed on 11/21/20 with				
	a quantity of 30 table					
		for Klor-Con 10meq from				
		ind no orders were received				
	to discontinue the me	edication.				
	-The facility's contrac	ted pharmacy provider did				
	•	dications from the residents'				
		er e-scripts or hard scripts to				
	fill medication orders.					
	-Klor-con was prescri	bed to prevent low				
	potassium levels.	a could lood to the west-to-				
	·	s could lead to the resident				
	experiencing abnorm	ai neait inyuiins.				
	Interview with the Adr	ministrator on 04/28/21 at				
	4:59pm revealed:	10.12 i di				
		ing Klor-Con 10meq daily.				
		Resident #2 receiving an				
	order to discontinue h					
		nistering Resident #2's				
	Klor-Con 10meq daily					
		answer as to how Resident				
	_	was administered after the				
		11/21/20 were depleted with				
	no refills until 03/08/2					
		Resident #2's Klor-Con				
	10med was not filled	and dispensed from the	1			

Division of Health Service Regulation

pharmacy from November 2020 until 03/08/21.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
			A. Boilbirto.			В
		FCL046002	B. WING		04	R I/28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
0.4.53/55		208 WAS	HINGTON ROAD			
CARVER	MANOR	MURFRE	ESBORO, NC 278	55		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	care provider's (PCP 3:28pm revealed: -The resident was las 2021The resident's potass was 3.8 which was no -There was no order idiscontinue Klor-Con -The staff at the facilit responsible for contact medication refills were -There was an expect	in the resident's record to 10meq. ty would have been cting the PCP when				
	Refer to the interview 04/28/21 at 4:59pm.	with the Administrator on				
	4:59pm revealed: -When she prepared residents' medication on the residents' med -She documented the on the residents' MAF medication to the resi-She did not have a nensure medications wordered such as com	s, she looked at the labels lication bottles. e medications administered R after administering the idents. nonitoring system in place to were administered as paring the FL-2, subsequent and residents' MARS to the				
	ordered for 2 of 3 resi Resident #3 received medication) twice dail instead of the ordered for anxiety which resu Ativan unnecessarily	ly on a scheduled basis d every 8 hours as needed ulted in the resident taking				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SI COMPLE	
					R	
		FCL046002	B. WING			8/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CARVER	MANOR		NGTON ROAD			
		MURFREE	SBORO, NC 2	7855		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 330	Continued From page	33	C 330			
	not administered Klor used to treat or preve evidenced by the med dispensed from the pi months which placed potassium levels which heart rhythms. The fadetrimental to the heat the residents and con The facility was provid accordance with G.S. this violation with an alon 05/07/21.	needed. Resident #3 was -Con 10meq as ordered int low potassium levels as dication not being filled and harmacy for approximately 3 the resident at risk for low ch could lead to abnormal cility's failure was alth, safety, and welfare of estitutes a Type B Violation. ded a plan of protection in 131D-34 on 04/28/21 for addendum on 05/04/21 and				
C 342	(j) The resident's merecord (MAR) shall be following: (1) resident's name; (2) name of the medic (3) strength and dosa medication administe (4) instructions for ad or treatment; (5) reason or justificat medications or treatment	4 Medication Administration dication administration e accurate and include the cation or treatment order; age or quantity of red; ministering the medication tion for the administration of tents as needed (PRN) and alting effect on the resident; dministration;	C 342			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:		, , ,	SURVEY PLETED	
		FCL046002	B. WING		04	R / 28/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	, ,	
		208 WAS	HINGTON ROAD			
CARVER	MANOR	MURFRE	ESBORO, NC 278	55		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 342	Continued From page	: 34	C 342			
	omission, including re (8) name or initials of the medication or trea signature equivalent t	the person administering atment. If initials are used, a o those initials is to be ntained with the medication				
	interviews, the facility medication administrator for 3 of 3 sampled resumedications used for potassium supplement anxiety and tremors/ii and medications used	as, record reviews and failed to ensure the ation records were accurate sidents related to seasonal allergies and a at (#2), high blood pressure, involuntary movements (#1) of for allergies, psychosis, involuntary movements,				
	The findings are:					
	03/16/21 revealed dia	t #2's current FL-2 dated ignoses included diabetes, essive-compulsive disease.				
	revealed: -She received all med -She was not sure wh	nt #2 on 04/28/21 at 9:25am dications from staff. eat kind of medications she dication were prescribed for.				
	03/16/21 revealed the Klor-Con 10meq daily used to treat or preve	v. (Klor-Con is a medication nt low potassium levels). 2's previous FL-2 dated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
			A. BUILDING:	A. BUILDING:		
		FCL046002	B. WING		04	R 4/ 28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
CARVER	MANOR	208 WAS	HINGTON ROAD			
CARVER	MANOR	MURFRE	ESBORO, NC 278	355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 342	Continued From page	e 35	C 342			
	Klor-Con 10meq daily	<i>1</i> .				
	-There was an entry f with a scheduled adm -Klor-Con 10meq was	ation record (MAR) revealed: for Klor-Con 10meq daily ninistration time of 8:00am				
	Review of Resident #2's February 2021 MAR revealed: -There was an entry for Klor-Con 10meq daily with a scheduled administration time of 8:00amKlor-Con 10meq was documented as administered daily at 8:00am from 02/01/21 - 02/28/21.					
	with a scheduled adm -Klor-Con 10meq was	or Klor-Con 10meq daily ninistration time of 8:00am.				
	facility's contracted pl 04/28/21 at 2:47pm re -Klor-con 10meq was a quantity of 30 tablet -Klor-Con 10meq was with a quantity of 30 t -Klor-Con 10meq was a quantity of 30 tablet	evealed: dispensed on 04/05/21 with ts. dispensed on 03/08/21 ablets. dispensed on 11/21/20 with				
		he resident's Klor-Con and dispensed from the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		ECI 04000	B. WING	B WING		0/2024
NAME OF D		FCL046002		TE 710 CODE	04/2	8/2021
	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
CARVER I	MANOR		SBORO, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 342	-She did not have an Klor-Con 10meg coul during that time since medication from 11/2 Refer to the interview aide/personal care aid 4:53pm. Refer to the telephone Pharmacist with the faprovider on 04/28/21 Refer to the interview 04/28/21 at 12:15pm Refer to the telephone the facility's primary on 04/28/21 at 3:28pr b. Review of Residen 03/16/21 revealed the an order for Cetirizine (Cetirizine HCL 10 mg treat seasonal allergie Review of Resident # 03/19/20 revealed the Cetirizine HCL 10 mg Review of Resident # medication administration administration administration administration and management of the control	mber 2020 until 03/08/21. answer how Resident #2's d have been administered there were no refills on the 1/20 until 03/08/21. with the medication de (MA/PCA) on 04/28/21 at e interview with a acility's contracted pharmacy at 2:47pm. with the Administrator on and 4:56pm. e interview with a nurse at care providers' office (PCP) m. t #2's current FL-2 dated are was an order there was a HCL 10 mg daily. g is a medication used to es). 2's previous FL-2 dated are was an order for a daily 2's February 2021 ation record (MAR) revealed: try for Cetirizine HCL 10 mg mentation Cetirizine HCL 10	C 342	DEFICIENCY		
	Review of Resident #	2's March 2021 MAR				

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revealed:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				R	
	FCL046002	B. WING		04/28/2021	
ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
MANOR					
(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE COMPL	ETE
Continued From page	e 37	C 342			
dailyThere was no docummg daily was adminis Review of Resident #revealed: -There was not an endailyThere was no docummg daily was adminis Observation of Residehand on 04/28/21 at 1 HCL 10 mg take daily a quantity of 30 tablet Interview with the meaide (MA/PCA) on 04 all the medications or	nentation Cetirizine HCL 10 stered. 2's April 2021 MAR try for Cetirizine HCL 10 mg nentation Cetirizine HCL 10 stered. ent #2's medications on 10:21am revealed Cetirizine of dispensed on 04/05/21 with ts. dication aide/personal care 1/28/21 at 10:20am revealed of hand for Resident #2 were				
facility's contracted ph 2:47pm revealed: -Cetirizine HCL 10 mg 04/05/21 with a quant -Cetirizine HCL 10 mg 03/05/21 with a quant Refer to the interview 04/28/21 at 4:53pm. Refer to the telephone Pharmacist with the fa provider on 04/28/21	g was dispensed on tity of 30 tablets. g was dispensed on tity of 30 tablets. g was dispensed on tity of 30 tablets. with the (MA/PCA) on e interview with a acility's contracted pharmacy at 2:47pm.				
	ROVIDER OR SUPPLIER MANOR SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page -There was not an endailyThere was no documm daily was adminis Review of Resident #revealed: -There was no documm daily was adminis Observation of Resident hand on 04/28/21 at and the current medical the cur	FCL046002 ROVIDER OR SUPPLIER STREET AL 208 WAS MURFRE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 37 -There was not an entry for Cetirizine HCL 10 mg daily. -There was no documentation Cetirizine HCL 10 mg daily was administered. Review of Resident #2's April 2021 MAR revealed: -There was not an entry for Cetirizine HCL 10 mg daily. -There was no documentation Cetirizine HCL 10 mg daily was administered. Observation of Resident #2's medications on hand on 04/28/21 at 10:21am revealed Cetirizine HCL 10 mg take daily dispensed on 04/05/21 with a quantity of 30 tablets. Interview with the medication aide/personal care aide (MA/PCA) on 04/28/21 at 10:20am revealed all the medications on hand for Resident #2 were all the current medications the resident was taking. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 04/28/21 at 2:47pm revealed: -Cetirizine HCL 10 mg was dispensed on 04/05/21 with a quantity of 30 tablets. -Cetirizine HCL 10 mg was dispensed on 03/05/21 with a quantity of 30 tablets. Refer to the interview with the (MA/PCA) on	ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STA 208 WASHINGTON ROAD MURFREESBORO, NC 2: SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 37 -There was not an entry for Cetirizine HCL 10 mg dailyThere was no documentation Cetirizine HCL 10 mg daily was administered. Review of Resident #2's April 2021 MAR revealed: -There was no documentation Cetirizine HCL 10 mg dailyThere was no documentation Cetirizine HCL 10 mg daily was administered. Observation of Resident #2's medications on hand on 04/28/21 at 10:21am revealed Cetirizine HCL 10 mg take daily dispensed on 04/05/21 with a quantity of 30 tablets. Interview with the medication aide/personal care aide (MA/PCA) on 04/28/21 at 10:20am revealed all the current medications the resident was taking. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 04/28/21 at 2:47pm revealed: -Cetirizine HCL 10 mg was dispensed on 04/05/21 with a quantity of 30 tablets. Refer to the interview with the (MA/PCA) on 04/28/21 at 4:53pm. Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy provider on 04/28/21 at 2:47pm.	TOURITHICATION NUMBER: ROWIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	FCLORRECTION DENTIFICATION NUMBER: B. WING

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04/28/21 at 12:15pm and 4:56pm.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. DOILDING.		
		FCL046002	B. WING		R 04/28/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
CARVER I	MANOR		INGTON ROAD		
		MURFREE	SBORO, NC 2	7855	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
C 342	Continued From page 38		C 342		
		e interview with a nurse at care providers' office (PCP) m.			
	2. Review of Residen 03/17/21 revealed:	t #1's current FL-2 dated			
	-Diagnoses included schizophrenia, essential hypertension, and obstructive sleep apneaThere was an order for Ativan 0.4mg three times				
	daily. (Ativan is a med anxiety).	dication used to treat for Metoprolol 50mg daily.			
		cation used to treat high			
	daily. (Cogentin is a n symptoms from antips	for Cogentin 2mg twice nedication used to treat sychotic medications to uch as tremors or involuntary			
	Review of Resident # 03/17/20 revealed:	1's previous FL-2 dated			
	daily.	for Ativan 0.4mg three times			
		for Metoprolol 50mg daily. for Cogentin 2mg twice			
	Review of Resident #1's February 2021 medication administration record (MAR) revealed: -There was an entry for Metoprolol 50 mg daily with a scheduled administration time of 8:00am with documentation of administration daily from 02/01/21 - 02/29/21.				
	daily with a scheduled 8:00am, 2:00pm and	for Ativan 0.5mg three times diadministration time of 8:00pm with documentation e times daily from 02/01/21 -			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDING: _		COMITECTED
		FCL046002	B. WING		R 04/28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
045)/55	208 WASH				
CARVER	MANOR	MURFREE	SBORO, NC 2	7855	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 342	Continued From page	÷ 39	C 342		
	-There was an entry f with a scheduled adm	or Cogentin 2mg twice daily ninistration time of 8:00am umentation of administration			
	Review of the Februa there were 28 days in	ry 2021 calendar revealed the month.			
	labeled as 1-28 and a dates of 03/29/21 and MAR indicating the da-There were compute entries in a boxed are-There was an entry f with a scheduled adm with documentation o 03/01/21 - 03/30/21. -There was an entry f daily with a scheduled	utter generated boxed areas handwritten entry for the doorwood of the ate of the month. If generated medication are on the left of the MAR. If Metoprolol 50 mg daily hinistration time of 8:00am of administration daily from the for Ativan 0.5mg three times doorwood of administration time of			
	of administration three 03/30/21. -There was an entry f with a scheduled adm and 8:00pm with doct twice daily from 03/01. -There was a handwr by "8am, 8am, 2pm, 8 the columns below th with no medication er areas on the left. Interview with the Adr 12:15pm revealed:	itten entry with "31" followed Bpm and 8pm" with initials in e hand written entry of "31" htries on the MAR'S boxed ministrator on 04/28/21 at residents' MARS from the			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	or dorate of the transfer of t	IDENTIFICATION NOMBER.	A. BUILDING:			D .
		FCL046002	B. WING		R 04/28/2	:021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CARVER	MANOR		INGTON ROAD SBORO, NC 2			
	CHMMADVCT		1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE C	(X5) COMPLETE DATE
C 342	Continued From page	2 40	C 342			
	the MARS were "cut of -The handwritten entr March 2021 MAR was -She did not realize th 03/31/21 did not reflect	e of the dates at the top of off". y of "31" on Resident #1's s for the date of 03/31/21. ne handwritten entry date for ct each medication that was esident at the scheduled				
	revealed: -He had lived at the faStaff at the facility admedicationsHe had not missed a that he was aware of because staff kept up Refer to the interview	ny doses of his medication but he was not sure with that.				
	aide/personal care aid 4:53pm.	de (MA/PCA) on 04/28/21 at				
	Refer to the telephone Pharmacist with the fa provider on 04/28/21	acility's contracted pharmacy				
	Refer to the interview 04/28/21 at 12:15pm	with the Administrator on and 4:56pm.				
		e interview with a nurse at are providers' office (PCP) n.				
	03/16/21 revealed: -Diagnoses included in unspecified psychosis disorder, and was not	s, unspecified mood n-verbal. for Zyrtec 10mg, 1 per day.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
	FCL046002 B. WING		R 04/28	/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
CARVER	MANOR	208 WAS	HINGTON ROAD			
CARVER	WANOR	MURFRE	ESBORO, NC 2	7855		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 342	Continued From page	e 41	C 342			
	-There was an order (Abilify is an antipsyc-There was an order day, nightly at bedtime depression)There was an order per day. (Cogentin tramedications)There was an order day. (Gavilax is a meconstipation)There was an order hours, as needed. (Alanxiety/agitation). Review of Resident # 01/04/21 revealed: -Diagnoses included unspecified psychosis disorder, and was notentated and the day of the day. (There was an order day, nightly at bedtimedepression)There was an order day. (Cogentin treats medications)There was an order day. (Cogentin treats medications)There was an order day. (Cogentin treats medications)There was an order day. (Cogentin treats medications).	for Abilify 10mg, I per day. hotic medication). for Remeron 15mg, 1 per e. (Remeron is used for for Cogentin 0.5mg, twice eats side effects from other for Gavilax 17g, once per dication used to treat for Ativan 0.5mg, every 8 tivan treats 3's previous FL-2 dated mental retardation, s, unspecified mood n-verbal. for Zyrtec 10mg, 1 per day. al allergies). for Abilify 10mg, I per day. hotic medication). for Remeron 15mg, 1 per e. (Remeron is used for for Cogentin 0.5mg, 1 per side effects from other for Cogentin 1mg, twice per side effects from other				

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anxiety/agitation).

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DIVISION	n nealth Service Negu	ialion			
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B. WING		R
		FCL046002	D. WING		04/28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE	
CARVER MANOR		INGTON ROAL			
		MURFREE	SBORO, NC 2	7855	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE
C 342	Continued From page	e 42	C 342		
	***	3's current assessment and			
	care plan dated 03/16				
		for Silas 60mg/15ml, twice			
	per day. (Silas treats	• ,			
	-The care plan was si	gned by the primary care			
	provider (PCP) on 03	/16/21.			
	Review of Resident #	3's February 2021			
		ation record (MAR) revealed:			
	-There was an entry f	or Zyrtec 10mg scheduled			
	daily at 8:00am.				
		tation that Zyrtec 10mg was			
	administered on 02/29	9/21-02/30/21.			
	-There was an entry f	or Abilify 10mg scheduled			
	every evening at 8:00				
	_	tation that Abilify 10mg was			
	administered on 02/29	, ,			
	-There was an entry f	or Remeron 15mg			
	scheduled for bedtime				
		tation that Remeron 15mg			
	was administered on	•			
		itten entry for Cogentin			
		at 8:00am and 8:00pm.			
		tation that Cogentin 0.5mg			
	was administered on	•			
		or Gavilax 17g in 8ox of			
	water scheduled daily	_			
	_	tation that Gavilax 17g was			
	administered on 02/29				
		or Ativan 0.5mg one tablet			
	_	ded for agitation or anxiety.			
		tation that Ativan 0.5 mg			
	was administered on				
		or Silas Syrup 4ml twice			
		• •			
	daily scheduled for 8:				
	-There was document				
	administered on 02/29				
		ary 2021 calendar, there			
	were only 28 days.		1		

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Division of	of Health Service Regu	lation			FORM APPROVED
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		FCL046002	B. WING		R 04/28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
CARVER	MANOR	208 WAS	HINGTON ROAD		
CARVER	MANOR	MURFRE	ESBORO, NC 2	7855	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 342	Continued From page	÷ 43	C 342		
	Review of Resident # revealed: -There was an entry f daily at 8:00amDocumentation for Z: 03/31/21 with no reas -There was an entry f every evening at 8:00 -Documentation for A: 03/31/21 with no reas -There was an entry f scheduled for bedtime -Documentation for R: 03/31/21 with no reas -There was a handwr: 0.5mg twice per day a: -Documentation for C: 03/31/21 with no reas -There was an entry f water scheduled daily -Documentation for G: 03/31/21 with no reas -There was an entry f water scheduled for 8: -Documentation for S: with no reason for the Review of Resident # revealed: -There was an entry f daily at 8:00amDocumentation for Z: 04/28/21 with no reas	3's March 2021 MAR or Zyrtec 10mg scheduled yrtec 10mg was blank on son for the omission. or Abilify 10mg scheduled ym. bilify 10mg was blank on son for the omission. or Remeron 15mg e at 8:00pm. emeron 15mg was blank on son for the omission. itten entry for Cogentin at 8:00am and 8:00pm. or Gavilax 17g in 8ox of or at 8:00am. ison for the omission. or Gavilax 17g was blank on son for the omission. or Gavilax 17g was blank on son for the omission. or Silas Syrup 4ml twice 00am and 8:00pm. ilas was blank on 03/31/21 e omission. 3's April 2021 MAR for Zyrtec 10mg scheduled yrtec 10mg was blank on			

omission.

0.5mg twice per day at 8:00am and 8:00pm.
-Documentation for Cogentin 0.5mg was blank on 04/28/21 at 8:00am with no reason for the

-There was an entry for Gavilax 17g in 8ox of

water scheduled daily at 8:00am.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		FCL046002	B. WING 04/2		04/28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE. ZIP CODE	
			INGTON ROAD		
CARVER	MANOR		SBORO, NC 2		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	J (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
C 342	Continued From page	2 44	C 342		
	04/28/21 at 8:00am womission. -There was an entry fidally scheduled for 8: -Documentation for Sat 8:00am with no real education of Residual educations of Residual educations. -The resident sat in a residual educations. -He was being non-verguestions. -He made eye contact smiled when spoken in the limit of the meaning (MA/PCA) on 04 she administered Residual educations.	or Silas Syrup 4ml twice 00am and 8:00pm. ilas was blank on 04/28/21 ason for the omission. dent #3 on 04/28/21 at chair in his bedroom. erbal and did not answer at, nodded his head, and to. dication aide/personal care //28/21 at 4:53pm revealed sident #3's medications			
	12:15pm and 4:56pm -She "just got carried documentation of extr Resident #3's Februal-Resident #3 always and never refused, shadminister his medical forgot to document the Refer to the interview 04/28/21 at 4:53pm. Refer to the telephone	away" with her ra days of administration on ry 2021 MAR. received his medications ne was probably rushing to ations on 03/31/21 and em. with the MA/PCA on e interview with a acility's contracted pharmacy			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		FCL046002	B. WING		04	R I/28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
CARVER	MANOR	208 WA	SHINGTON ROAD			
CARVER	WANOK	MURFR	EESBORO, NC 278	55		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 342		w with the Administrator on	C 342			
	Refer to the telepho	ne interview with a nurse at care provider's office (PCP)				
	aide (MA/PCA) on Construction of Construction	residents in one at a time to cations and ensure each nedication. cument the administration of the residents' medication d (MAR) after observing the				
	facility's contracted 04/28/21 at 2:47pm -The pharmacy did MARs for the facility -The facility was res residents' MARSIt was important to	not provide the residents' ponsible for creating the ensure medications were tely when administered to				
	12:15pm and 4:56pd -Her process for addinctuded making a " to give the residents MAR. -She then pulled the residents to her office	dministrator on 04/28/21 at m revealed: ministering medications little list" of what medications instead of referencing the e medications and called the ce one by one to administer densure each resident took				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILBING.		R	
		FCL046002	B. WING	B. WING 04/2		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
CARVER	MANOR		SHINGTON ROAD			
040.15	STIMMADY ST	ATEMENT OF DEFICIENCIES	ESBORO, NC 2	PROVIDER'S PLAN OF CORRECTION	1 0/5	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
C 342	Continued From page	e 46	C 342			
C 381	and document the methe resident MAR. -There was no procest administration of medication are for safe medication are she would audit resimenths for MAR accuracently. Telephone interview or primary care provider at 3:28pm revealed it facility to accurately of medications for the	nedications first and ations, then go back later edication administration on as in place to compare the dications to the MAR orders	C 381			
	10A NCAC 13G .1009 (b) The facility shall a needed in response t documented, includin appropriate health proinformed of the findin. This Rule is not met Based on interviews a facility failed to ensur response to the quart recommendations for (Resident #2) related. The findings are:	9 Pharmaceutical Care assure action is taken as to the medication review and ag that the physician or ofessional has been gs when necessary.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
			A. BOILBING:			В
		FCL046002	B. WING		04	R 4 28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
		208 WAS	HINGTON ROAD			
CARVER	MANOR	MURFRE	ESBORO, NC 278	355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 381	obsessive-compulsive -The resident was inte -The resident was and -There were handwritt page 1 of the FL-2There were typed mo of the FL-2There was a medicat every hour of sleep. (for anxiety)There was a medicat every 6 hours. Review of Resident # reviews revealed: -On 02/24/21 there w Ativan should be obtat ordered by the primate -On 11/27/20 there w was not in stock and administered as orde order obtained for the -On 08/21/20 there w was not on handOn 02/25/20, there w was out of stock and resident use. Observation of Resid hand on 04/28/21 at a was not available for Interview with the Adr 4:59pm and 5:36pm r -She completed the re PCP signed the FL-2.	diabetes, hypertension and e disorder. ermittently disoriented. abulatory. ten medication orders on edication orders on page 2 tion order for Ativan 0.5mg Ativan is a medication used tion order for Ativan 0.5mg 2's quarterly pharmacy as documentation that ained and administered as ry care provider (PCP). as documentation Ativan should be obtained and red or a discontinuation e resident's record. as documentation Ativan should be replaced for ent #2's medications on 10:21am revealed Ativan administration. ministrator on 04/28/21 at revealed: esident's FL-2's and the	C 381			
	-She had contacted F resident's mental hea	Resident #2's PCP and the Ith provider and both				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL046002	B. WING		04	R / 28/2021	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE		72072021	
CARVER	MANOR	208 WAS	HINGTON ROAD				
OAKVEK	MANOK .	MURFRE	ESBORO, NC 27	855			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
C 381	1 Continued From page 48		C 381				
	who prescribed Atival -Resident #2 had not -Resident #2's previo the resident.	taken Ativan in months. us PCP ordered Ativan for ss in place to ensure follow					
	health provider's nurs	with Resident #2's mental se on 04/28/21 at 2:01pm nealth provider was not the or Resident #2's Ativan.					
	nurse on 04/28/21 on	with a Resident #2's PCP's 3:28pm revealed: was not prescribed by the					
	medications and had medication since 201 -Resident #2 should receiving Ativan.						
	for Resident #2's Ativ -The facility would ha	an to be discontinued. ve been responsible to recommendations were					
C 912	G.S. 131D-21(2) Dec	laration of Residents' Rights	C 912				
	Every resident shall r 2. To receive care ar adequate, appropriate	e, and in compliance with state laws and rules and					
		as evidenced by. ns, interviews, and record					

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
FCL046002		B. WING			R 04/28/2021	
IAME OF BROWINER OR SLIDBLIER		DDESS CITY STAT	E ZIR CODE	1 01	720/2021	
AWE OF FROVIDER OR SUFFLIER		HINGTON ROAD	E, ZIF CODE			
CARVER MANOR		SBORO, NC 27	855			
PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
reviews, the facility fails had the right to receive are adequate, appropri with rules and regulation and construction, medimanagement and other. The findings are: 1. Based on observation reviews, the facility fails evacuation capabilities the evacuation (Types and Construction (Types 2. Based on interviews facility failed to an as needed. 2. Based on interviews facility failed were administered according (#3). [Refer to Tale 1.0601(d) Management Violation)]. 3. Based on observation reviews, the facility failed were administered according the resid (PCP) for 2 of 3 sample related to an as needed.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 49 reviews, the facility failed to ensure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to design and construction, medication administration, and management and other staff. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 2 of 3 sampled residents (#2 and #3) who had cognitive impairments and/or physical impairments and required verbal prompting to exit the facility during a fire drill. [Refer to Tag C0022, 10A NCAC .0302(b) Design and Construction (Type B Violation)]. 2. Based on interviews and record reviews, the facility failed to ensure sufficient staff were on duty and awake at all times to meet the supervision needs for 2 of 4 residents (#2 and #3) who had a diagnosis of dementia (#2) and with significant memory loss requiring redirection and extensive/total assistance with activities of daily living (#3). [Refer to Tag C0191, 10A NCAC 13G .0601(d) Management and Other Staff (Type A2					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:				
			71. 201231110.			R		
		FCL046002	B. WING			/28/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	ΓΕ, ZIP CODE				
208 WASHINGTON ROAD								
CARVER MANOR MURFREESBORO, NC 27855								
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)			COMPLETE		

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