STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 11/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	321 EAST CARVER STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to apply a wheelchair alarm as indicated per the care plan for 1 of 9 sampled residents (Resident #235). Resident #235 was admitted to the facility on 10/17/11. Cumulative diagnoses included Dementia and Altered Mental Status. The admission Minimum Date Set (MDS) completed on 10/29/11 indicated Resident #235 cognitive status was severely impaired. The MDS revealed Resident #235 required extensive assist with transfer and walk in the corridor or unit. His balance was indicated not steady and only able to stabilize with human assistance with walking. A review of the care plan dated 10/20/11 revealed Resident #235 was identified a potential for falls due to a decline in cognitive status and unsteady gait. The care plan dated 10/24/11 indicated "Chair alarm on when in chair." A review of the fall investigations for Resident #235 completed on 10/19/11, 10/27/11 revealed the resident was found in the floor both dates in his room, due to attempted to stand unassisted. As part of the interdisciplinary follow up completed on 10/25/11 the facility added a chair	F 282	*This plan of Correction is the Carver Living Center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by provisions of federal and state law.* F 282 1. The chair alarm for resident #235 was placed on the resident's chair and tested for functioning. 11/08/11 NA #1 was counseled and then in-service on following and implementing the care plan developed by the facility's interdisciplinary team. 11/08/11 2. The facility identified all residents with any fall interventions on their individual care plans. 11/11/11	11/08/11 11/08/11 11/11/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: J. M. Carpenter | TITLE: Administrator | (X6) DATE: 11/23/2011

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

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F 282	Continued From page 1 alarm as a short term approach. On 10/27/11, the facility indicated as part of the interdisciplinary team follow up for long term approaches, a chair alarm intervention. The resident was documented as noncompliant with following the facility's fall prevention interventions. On 11/8/11 at 11:05 AM, Resident #235 was observed sitting in the wheelchair in front of the 400 hall nurses station. There was no alarm attached to the wheelchair. The staff was not within view of the resident for 4 minutes. In an interview on 11/8/11 at 11:10 AM, Nurse #1 stated the resident was a fall risk due to unsteady gait and had a tendency to stand up unassisted. Nurse #1 informed she had not checked the resident since coming on her shift to ensure the wheelchair alarm was intact. She added she expected the nursing assistant (NA) to have put the alarm to the wheelchair after placing the resident in the wheelchair. In an interview on 11/8/11 at 11:25 AM, NA #1 indicated she was aware Resident #235 was to have a wheelchair alarm in place when in the wheelchair. NA #1 added she did not recall putting the alarm to the wheelchair after getting the resident up for the morning. NA #1 concluded Resident #235 did have a tendency to stand unassisted and was at risk for falls due to unsteady gait. In an interview on 11/8/11 at 11:40 AM, the Director of Nursing (DON) indicated she expected all staff to ensure the resident wheelchair alarm was intact. She added the resident did have a tendency to take the alarm off. The DON	F 282	The facility's D.O.N. and her designees compared all the care plans of identified residents with the actual intervention practiced and directed specific clinical action if appropriate. 11/28/11 Facility Department Managers will check that all fall preventative equipment is in place for the appropriate residents as part of their Guardian Angel Rounds five times per week. 11/28/11 and Ongoing 3. Clinical staff received in-service training regarding following and implementing care plans for residents, as developed by the facility's interdisciplinary team. 11/28/11 The facility's D.O.N. and her designees will conduct audits of a random resident sample four times the first week following the state's recertification survey then twice a month for one month, once a month for	11/28/11 11/28/11 11/28/11

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F 282	Continued From page 2 concluded she expected the alarm to be intact to the wheelchair as indicated per the care plan.	F 282	two months and once per quarter for three quarters. 11/18/11	11/18/11
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to date multi-dose vials of a tuberculin diagnostic agent when opened in 2 of 4 medication rooms, and failed to remove expired insulin vials from 2 of 7 medication carts. Findings include: 1. The facility policy titled Expiration of Opened Multi-Dose Vials, undated, page 36, read in part	F 425	4. The Nursing Department will present the findings of all care plan compliance audits at the facility's QA Committee monthly for four months and then quarterly for three quarters. 11/10/11 Facility Department Managers will review the results of their Guardian Angel Rounds at the facility's daily QA Meeting five times per week. 11/28/11	11/10/11 11/28/11

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F 425	Continued From page 3 "Policy: All multi-dose vials of injectable medications and vaccines shall be dated by the designated staff person at the time that the seal is broken and the first dose drawn. Subsequently, the following expiration dates shall be observed: 30 days: PPD (Tuberculin Purified Protein Derivative)." An inspection of the 300 hall medication room refrigerator on 11/8/11 at 3:09PM revealed two, opened, undated multi-dose vials of PPD. PPD is a diagnostic agent used as a skin test for tuberculosis. The manufacturer's product information for storage requirements read in part: "A vial of PPD which has been entered and in use for 30 days must be discarded." The manufacturer's label on the PPD vial read "Discard opened product after 30 days." Oxidation and degradation may occur after 30 days resulting in reduced potency and possible inaccurate test results. In an interview on 11/8/11 at 3:12PM, Nurse # 2 acknowledged the vials of PPD were opened but not dated. She stated the vials should have been dated by whoever opened them. She stated no staff was assigned to check the refrigerator to her knowledge. Nurse #2 stated the pharmacist checked the refrigerator but she wasn't sure how often. In an interview on 11/8/11 at 4:08PM, the Director of Nursing stated the staff was supposed to date all injectable multi-dose vials when the seals were opened. She stated PPD vials had 30 day expiration date after opening. The staff audited the medication rooms periodically and the pharmacist also checked them monthly. Her	F 425	F 425 1. The facility immediately disposed of all identified expired multi-dose medication vials. 11/8/11 2. All medication rooms, refrigerators and carts were audited for multi-dose medication vials for appropriate labeling. 11/10/11 The facility in-serviced licensed nurses to clarify labeling of multi-dose medication vials. 11/22/11 3. The facility's D.O.N. and her designees will randomly monitor multi-dose medication vials for labeling accuracy and storage four times in one week following the state's recertification survey, twice per month for two months, once per month for three months. 11/18/11	11/8/11 11/10/11 11/22/11 11/18/11

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F 425	Continued From page 4 expectation was for the staff to date PPD vials when opened and discard them after 30 days. The pharmacist was unavailable for interview. 2. The facility policy titled Expiration of Opened Multi-Dose Vials, undated, page 36, read in part "Policy: All multi-dose vials of injectable medications and vaccines shall be dated by the designated staff person at the time that the seal is broken and the first dose drawn. Subsequently, the following expiration dates shall be observed: 30 days: PPD." An inspection of the 100 hall medication room refrigerator at on 11/8/11 at 3:40PM revealed one, opened, undated multi-dose vial of PPD. PPD is a diagnostic agent used as a skin test for tuberculosis. The manufacturer's product information for storage requirements read in part: "A vial of PPD which has been entered and in use for 30 days must be discarded." The manufacturer's label on the PPD vial read "Discard opened product after 30 days." Oxidation and degradation may occur after 30 days resulting in reduced potency and possible inaccurate test results. In an interview on 11/8/11 at 3:45PM, Nurse # 4 acknowledged the vial of PPD was opened but not dated. She stated whoever opened the vial should have dated it. Nurse #4 stated the night shift staff checked the refrigerator. She was not sure how long the PPD could be used after it was opened. In an interview on 11/8/11 at 4:08PM, the Director of Nursing stated the staff was supposed to date	F 425	The facility's pharmacy consultant will monitor all multi-dose medication vials monthly and include the results in the Consultant Report. 11/28/11 4. The Nursing Department will present the results of the multi-dose medication vial monitoring monthly at the facility's QA Committee meeting. 11/10/11 The Pharmacy Consultant will present the Consultant Report quarterly at the facility's QA Committee meeting. 11/10/11	11/28/11 11/10/11 11/10/11

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F 425	Continued From page 5 all injectable multi-dose vials when the seals were opened. She stated PPD vials had 30 day expiration date after opening. The staff audited the medication rooms periodically and the pharmacist also checked them monthly. Her expectation was for the staff to date PPD vials when opened and discard them after 30 days. The pharmacist was unavailable for interview. 3. The facility policy titled Expiration of Opened Multi-Dose Vials, undated, page 36, read in part "Policy: All multi-dose vials of injectable medications and vaccines shall be dated by the designated staff person at the time that the seal is broken and the first dose drawn. Subsequently, the following expiration dates shall be observed: 28 days: Insulin products." An inspection of the 300 hall medication cart #1 on 11/8/11 at 3:20PM revealed one 10cc (cubic centimeters) vial of Novolin (insulin) R (regular), with an opened date of 9/5/11. The manufacturer's product information for Novolin R read in part: "Storage - Novolin R vials in use: throw away an opened vial after 6 weeks (42 days) of use, even if there is insulin left in the vial." In an interview on 11/8/11 at 3:25PM, Nurse #3 examined the insulin vial and acknowledged it had expired. She stated there was a 42 day expiration date on all insulin products after they were opened except for Lantus. Nurse #3 stated she had attended a pharmacy in-service on insulin storage within the last few weeks. She stated each nurse was responsible for checking	F 425		

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F 425	Continued From page 6 their cart for outdated items. The pharmacist also checked regularly during her monthly visits. In an interview on 11/8/11 at 4:08PM, the Director of Nursing stated the staff was supposed to date all injectable multi-dose vials, including insulin, when the seals were opened. She stated the pharmacist checked the drug storage areas monthly for outdated items. The facility staff also conducted audits periodically. The staff was supposed to check the dates on the insulin vials each time before administration. Her expectation was for the staff to check expiration dates every time insulin was given, discard the vial if past the expiration date, and open and date the new vial. The pharmacist was unavailable for interview. 4. The facility policy titled Expiration of Opened Multi-Dose Vials, undated, page 36, read in part "Policy: All multi-dose vials of injectable medications and vaccines shall be dated by the designated staff person at the time that the seal is broken and the first dose drawn. Subsequently, the following expiration dates shall be observed: 28 days: Insulin products." An inspection of the 300 hall medication cart #2 on 11/8/11 at 3:23PM revealed one 10cc vial of Novolog (insulin), with an opened date of 9/19/11, and one 10cc vial of Humulin (insulin) R, with an opened date of 10/3/11. The manufacturer's product information for Novolog read in part: "Recommended Storage - Novolog, vials: after initial use a vial may be kept at temperatures below 30 degrees Celsius (86 degrees Farenheit) for up to 28 days."	F 425		

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F 425	Continued From page 7 The manufacturer's product information for Humulin R read in part: "Storage, in-use (opened): In-use vials must be used within 31 days or be discarded." In an interview on 11/8/11 at 3:25PM, Nurse #3 examined the insulin vials and acknowledged they had expired. She stated there was a 42 day expiration date on all insulin products after they were opened except for Lantus. Nurse #3 stated she had attended a pharmacy in-service on insulin storage within the last few weeks. She stated each nurse was responsible for checking their cart for outdated items. The pharmacist also checked regularly during her monthly visits. In an interview on 11/8/11 at 4:08PM, the Director of Nursing stated the staff was supposed to date all injectable multi-dose vials, including insulin, when the seals were opened. She stated the pharmacist checked the drug storage areas monthly for outdated items. The facility staff also conducted audits periodically. The staff was supposed to check the dates on the insulin vials each time before administration. Her expectation was for the staff to check expiration dates every time insulin was given, discard the vial if past the expiration date, and open and date the new vial. The pharmacist was unavailable for interview.	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441	F 441 1. The glucometer used for resident #235 was completely sanitized. 11/8/11	11/8/11

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F 441	Continued From page 8 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to properly disinfect a glucometer for 1 of 1 sampled resident (resident	F 441	The licensed nurse #1 was counseled and received in-servicing regarding following proper infection control procedure. 11/8/11 2. All facility glucometers were completely sanitized. 11/8/11 Facility licensed nurses were re-inserviced on specific glucometer sanitation technique and infection control procedures in general. 11/8/11	11/8/11 11/8/11 11/8/11

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F 441	Continued From page 9 #235) observed receiving blood glucose monitoring. Findings include: The facility's policy titled Blood Glucose Monitoring and Cleansing, dated 9/20/11, read in part: "Resident Blood Glucose Testing Procedure: Cleanse glucose monitor with Sani Wipes. Let dry for 2 minutes before re-using the glucometer." The Center for Disease Control (CDC) and Prevention Guidelines for Glucose Monitoring read in part: "Any time blood glucose monitoring equipment is shared between individuals there is a risk of transmitting viral hepatitis and other blood borne pathogens. Decontaminate environmental surfaces such as glucometers regularly and any time contamination with blood or body fluids occurs or is suspected. Glucose test meters approved for use with more than one person must be cleaned and disinfected following disinfection guidelines." Accu-check or fingerstick blood sugar (FSBS) tests involve sticking a resident's finger for a blood sample, which is then placed on a strip. The strip goes into a glucose meter that reads the blood sugar level. Resident #235 was admitted to the facility on 10/17/11 with multiple diagnoses including diabetes. Review of the resident' s clinical record revealed a physician order dated 10/17/11 for FSBS four times daily. Observation on 11/8/11 at 11:28AM revealed nurse #1 preparing to obtain a finger stick blood sugar for resident #235. Nurse #1 removed the	F 441	3. The facility's D.O.N. and her designees will conduct random monitoring of glucometer sanitizing technique for five days, three times per week for three weeks, once per week for four weeks, and once per month. 11/16/11 4. The facility's Nursing Department will report monthly the results of the glucometer sanitizing audits to the QA Committee. 11/10/11	11/16/11 11/10/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	Continued From page 10 glucometer from the medication cart and inserted a test strip into the glucometer. Nurse #1 wiped the resident's finger with an alcohol pad, obtained a blood sample by disposable lancet, and applied a drop of blood to the test strip. After reading the test results, Nurse #1 removed the test strip. Nurse #1 disposed of the used test strip, alcohol pad, and lancet. Nurse #1 wiped the end of the glucometer where the strip had been inserted with a disinfectant wipe. Nurse #1 did not disinfect any other areas of the glucometer. In an interview on 11/8/11 at 11:33AM, Nurse #1 stated she was trained when hired and periodically thereafter on the proper use and cleaning of glucometers. Nurse #1 stated she was trained to wipe the entire surface of the glucometer with a disinfectant after each use. Nurse #1 acknowledged she had only disinfected the area where the test strip was inserted into the glucometer. She stated "it was just a case of nerves today, I forgot." In an interview on 11/8/11 at 4:55PM, the Director of Nursing (DON) stated the staff was trained when hired and in-serviced periodically thereafter on the proper use and cleansing of glucometers. The staff was monitored by the DON, assistant DON, and pharmacist during medication pass observations. The DON stated the entire surface of glucometers should be wiped with a disinfectant after each use. Her expectation was for staff to follow proper procedures for cleaning and disinfecting glucometers during FSBS monitoring.	F 441		

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OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	345434	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/09/2011

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K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: A. Based on observation on 12/09/2011 there is a 3 inch PVC conduit that is not properly sealed penetrating the rated ceiling of the main switch gear room. 42 CFR 483.70 (a)	K 012	1. A special fire expansion ring was installed around the pvc pipe located in the mechanical room. 2. All facility mechanical rooms were inspected for properly sealed wall and ceiling penetrations. 3. All facility mechanical rooms will be inspected for properly sealed wall and ceiling penetrations as a component of the facility's monthly inspection schedule. 4. The results of the monthly mechanical room inspections will be presented to the facility's Quality Assurance Committee for three months. The QA Committee will make recommendations as appropriate.	12/17/11 12/09/11 12/09/11 and ongoing 12/09/11 and Ongoing
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 12/09/2011 the only exit door with a magnetic lock would relock when the FACP was placed in the silent mode. B. Based on observation on 12/09/2011 there is an exit from the laundry does not have an exit discharge path to a public way. 42 CFr 483.70 (a)	K 038	1. The breezeway door magnetic lock was repaired and functions properly. 2. All facility doors with magnetic locks were checked for proper function.	12/13/11 12/08/11
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA	K038a K 062	See attached.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeff Carpenter — TITLE: Administrator — (X6) DATE: 12/22/2011

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING 02 - BUILDING 02 B. WING	12/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	321 EAST CARVER STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: A. Based on observation on 12/09/2011 there was a lack on egress lighting for the exit discharge path out side the lcked unit. 42 CFR 483.70 (a)	K 045	1. Lights were installed to the exterior corner of the 200 Hall. 2. The entire exterior of the facility was inspected to ensure that there is sufficient exterior lighting. 3. The facility's exterior lighting will be inspected weekly for three months and then monthly as a component of the facility's monthly inspection schedule. 4. The results of the weekly exterior lighting inspections will be presented to the Facility's Quality Assurance Committee monthly for three months. The QA Committee will make recommendations as appropriate.	12/16/11 12/16/11 12/14/11 and ongoing 12/08/11 and Ongoing
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: A. Based on observation on 12/09/2011 there were mixed sprinkler heads in the 100 Hall dining room. All sprinkler heads in the same smoke area must be the same or shown to be compatible . 42 CFR 483.70 (a)	K 062 K062	1. The sprinkler heads in the 100 Hall Dining Room area and kitchen dry storage area were inspected by a certified sprinkler company and found to be completely compatible.	12/19/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeff Carpenter — TITLE: Administrator — (X6) DATE: 12/22/2011

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

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Continue K038a	3. All facility doors with magnetic locks will be checked monthly as a component of the facility's monthly inspection schedule.	12/08/11
	4. The results of the monthly magnetic door lock checks will be presented to the facility's Quality Assurance Committee for three months. The QA Committee will make recommendations as appropriate.	12/08/11 and Ongoing
K038b	1. A discharge path will be constructed from the laundry exit door to a public way.	01/23/12
	2. All facility exits were checked to ensure that there was a discharge path to a public way.	12/08/11
	3. A monthly check will be made to ensure that all exits have free and clear discharge paths to a public way.	12/08/11 and Ongoing
	4. The results of the monthly discharge path checks will be presented to the Facility's Quality Assurance Committee annually.	12/08/11 and Ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	321 EAST CARVER STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 1 26, 9.7.5 This STANDARD is not met as evidenced by: A. Based on observation on 12/09/2011 there were mixed sprinkler heads in the dry storage room of the kitchen. The sprinkler heads in the same smoke area must be the same or shown to be compatible to each other. 42 CFR 483.70 (a)	K 062	1. The sprinkler heads in the 100 Hall Dining Room area and kitchen dry storage area were inspected by a certified sprinkler company and found to be completely compatible.	12/19/11
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: A. Based on observation on 12/09/2011 the GFCI receoticals in the bath room of rooms 401,493, 413 and several more failed to work when tested. 42 CFR 483.70 (a)	K147	1. The cited GFCI receptacles were replaced. 2. All facility GFCI receptacles were tested. 3. All facility GFCI receptacles will be tested weekly for three months, then tested monthly as a component of the facility's monthly inspection schedule. 4. The results of the weekly GFCI receptacle tests will be presented to the facility's Quality Assurance Committee for three months. The QA Committee will make recommendations as appropriate. *This plan of Correction is the Carver Living Center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by provisions of federal and state law.*	12/08/11 12/14/11 12/14/11 12/08/11 and Ongoing