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

PRINTED: 05/31/2017 FORM APPROVED OMB NO. 0938-0391

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
	345434	B. WING _			017	
NAME OF PROVIDER OR SUPPLIER CARVER LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 321 EAST CARVER STREET DURHAM, NC 27704			
ID SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL G REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE CO	OULD BE COMPLETION	
000 INITIAL COMMENTS		F 0	00			
DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	RF	TITLE	(X6) E	ATE	
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR IN INITIAL COMMENTS No deficiencies were complaint investigation	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS No deficiencies were cited as a result for the complaint investigation Event ID # 0NCJ11.	A. BUILDIN 345434 B. WING _ ROVIDER OR SUPPLIER LIVING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS F 0 No deficiencies were cited as a result for the	CORRECTION IDENTIFICATION NUMBER: 345434 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 321 EAST CARVER STREET DURHAM, NC 27704 PROVIDERS PLAN OF CORR (EACH CORRECTIVE MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTIONS) REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS No deficiencies were cited as a result for the complaint investigation Event ID # 0NCJ 11.	COMPLETE 345434 8. WING STREET ADDRESS, CITY, STATE, JIP CODE 321 EAST CARVER STREET DURHAM, NC 27704 SUMMARY STATEMENT OF DEROIENCIES (EACH DEPOLENCY MUST BE PRECEDED BY PULL REGULATORY ON LSC IDENTIFYING INFORMATION) INITIAL COMMENTS No deficiencies were cited as a result for the complaint investigation Event ID # ONC.J11.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed 04/27/2017

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.