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 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	**303 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 000	INITIAL COMMENTS An unannounced complaint survey was conducted 3/27/2023 through 3/31/2023. The following intakes were included in the survye; NC00200274, NC00200148, NC00200143, NC00200017, NC00200057, NC00199777, NC001999801, NC00199538, NC00199448. Event ID#OK1811. 3 of the 18 allegations resulted in a deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		4/14/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 04/14/2023

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 550	Continued From page 1 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff, the facility failed to treat a resident with dignity when a Nurse Assistant (NA) was observed yelling at resident while assisting with care for 1 of 3 (Resident #2) observed for dignity. The reasonable person concept was applied to this deficiency as individuals have the expectation of being treated with dignity while in their home environment. The findings included: Resident #2 was admitted to the facility on 3/15/2023 with diagnosis that included vascular dementia with agitation. The resident's Minimum Data Set (MDS) was not yet completed. Resident #2's comprehensive care plan had a focus for impaired thought process and function related to diagnosis of dementia.	F 550	F 550 Dignity Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; NA #1 was suspended on 3/27/2023 following the incident of being disrespectful to resident #2 while receiving care. Resident #2 was assessed by the licensed nurse on 3/27/2023, following the incident to identify any mental or physical concerns related to the incident. The resident did not recall the incident that someone had been disrespectful while receiving care. The licensed nurse notified the medical	

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F 550 Continued From page 2

Resident #2's most recent psychiatry progress note by the Psychiatric Mental Health Nurse Practitioner (PMHNP) was dated 3/26/2023 and indicated the resident had a history of vascular dementia and placement in the memory care unit was appropriate. The progress note also indicated staff denied any mood or behavior changes and the treatment plan included his current medications and supportive care.

On 3/27/2023 at 10:55AM while on the memory care unit, this surveyor heard yelling. While walking down the hall to find the source of the yelling, surveyor observed NA#2 turn away from the linen cart and begin to look for the source of the yelling as well. Surveyor observed NA #1 standing at Resident #2's bedside yelling, " I ain't fixin to fight with you. You gonna fall. You gonna fall." The resident was observed lying in the bed in left lateral recumbent position, wearing a shirt and incontinent brief, attempting to get up. NA#2 stepped into the room and asked NA#1 if she would like assistance with Resident #2. Surveyor stepped into the hall and NA#2 closed the door to provide privacy as she assisted NA#1. Surveyor walked down to the hall and made the Charge Nurse aware of the observation. The Charge nurse walked down the hall and entered the resident's room. The resident was observed exiting the room at that time.

Attempts to interview NA#2 were denied. She stated, " I am leaving right now. I am not about to get into trouble over this." The NA was observed leaving the memory care unit.

On 3/27/2023 at 11:15AM an interview was conducted with NA#2. She stated she heard the yelling and looked to see where the yelling was

F 550

provider and the resident representative on 3/27/2023, regarding the incident that resident #2 had been disrespected while receiving care by a staff member.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

Current facility residents have the potential to be affected by the alleged deficient practice failure to treat a resident with dignity and respect.

The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers(UM) and Social Service Director (SSD) completed interviews and observations on 3/27/23, for current facility residents , to identify any concerns related to the residents not being treated with dignity and respect. There were no other concerns regarding dignity or respect.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

The DON, ADON, UM and SSD completed education on Resident Rights for current facility staff, regarding treating residents with dignity and respect. The education included that staff must treat

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F 550	Continued From page 3 coming from. She stated the resident was not allowing NA#1 to complete care. NA#2 stated yelling at confused residents can escalate behaviors and should be avoided. NA#2 stated she stepped into the room and assisted NA#1. Resident #1 was not able to participate in an interview on 3/27/2023 at 11:45AM due to cognitive impairment. He was observed fully dressed walking up and down the hall. The resident did not appear to be in distress. On 3/27/2023 at 11:45AM an interview was conducted with the Charge Nurse. She stated she did not hear the NA yelling at Resident #2. She stated when she got to the resident's room, NA#1 stated she was leaving because she was not going to get into trouble. The Charge Nurse stated NA #1 was agency staff and it was her first day working in the unit. She was not familiar with the residents. An interview was conducted with the Administrator on 3/27/2023 at 1:00PM. She stated NA#1 provided her statement regarding the incident. She further stated the NA was on suspension pending an investigation and she was completing the mandatory reporting to the state. The Administrator stated it was her expectation that staff refrain from yelling at confused residents.	F 550	each resident with dignity and respect, and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. The facility is responsible for protecting and promoting the rights of the residents. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON, ADON, UM and SSD will conduct 20 resident interviews or observations weekly for 4 weeks then 40 per month for 2 months. The DON or SSD will review the interviews/observations monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON or SSD will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; Corrective Action will be completed on 4/14/23.	