APR 3 0 2013

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

PRINTED: 04/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE:	
() (集) ()			A. BUILD			, ا	,
		345434	B. WNG			03/2	, 20/2013
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CARVERI	usuo oruzen		1		EAST CARVER STREET		
CARVERI	LIVING CENTER			DUF	RHAM, NC 27704		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG		CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD: CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
F 225	483.13(c)(1)(ii)-(iii),	(c)(2) - (4)	F	225			
SS≍D	INVESTIGATE/REP	PORT		- 1			
	ALLEGATIONS/IND	DIVIDUALS					
	The facility must not	t amplay individuals who have					
	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide				•		
					THIS RESPONSE AND		
					PLAN OF CORRECTION		
		abuse, neglect, mistreatment			IS BEING SUBMITTED		
İ		ppropriation of their property;			,		•
		vledge it has of actions by a			PURSUANT TO THE		
	}	an employee, which would			APPLICABLE FEDERAL		
indicate unfitness for sen		the State nurse aide registry			AND STATE		
	or licensing authorit				REGULATIONS. NOTHI		
	or noonoing dament						
,	The facility must en	sure that all alleged violations			NG CONTAINED HEREIT	1	
. ` 		ent_neglect_or_abuse;			SHALL BÈ CONSTRUED		
		unknown source and			AS AN ADMISSION		
		resident property are reported			THAT THE FACILITY		
		administrator of the facility and					
		accordance with State law I procedures (including to the			VIOLATED ANY		
	State survey and ce			Ì	FEDERAL OR STATE		
	Oldie Salvey and oc	stanoadon agonoy).			REGULATION, OR		
	The facility must ha	ve evidence that all alleged			FAILED TO FOLLOW	,	
	violations are thoro	ughly investigated, and must					
	prevent further pote	ential abuse while the			ANY APPLICABLE		
	investigation is in p	rogress.			STANDARD OF CARE,		
	The results of all in	vestigations must be reported					
•	to the administrator						
	1	to other officials in accordance					
		uding to the State survey and					
) within 5 working days of the					
		alleged violation is verified					
	appropriate correct	ive action must be taken.					
		امر					
	Consideration of the control	PUSUPPLIER REDRESENTATIVE'S SIGNATU	loc l		TITLE		(X6) DATE

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that it safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days slowing 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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TATEMENT OF DEFICIENCIES LPLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		346434	B. WING				C /20/2013
	OVIDER OR SUPPLIER			120/2010			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY))TD BE	(X5) COMPLETION DATE
F 225	by: Based on record refacility failed to thorallegation of resident residents (Resident day report of an allest the Health Care Persampled residents (included: 1. Resident #3 was 1/9/12. The admissicompleted on 1/21/cognitive status was A review of the 5 da 3/6/13 by the social of resident abuse the states that an aide in threw him on the bewas pulling on his coor the description of the description of the allegal as part of the invest #3, and that Reside accurate description could he recall the occurred. The invest Resident #3 was quinad been rough with There was no additional and the record of the recall the occurred was no additional resident #3 was quinad been rough with There was no additional resident #3 was quinad been rough with There was no additional resident #3 was quinad been rough with There was no additional resident #4	view and staff interviews, the bughly investigate an at abuse for 1 of 2 sampled #3) and failed to submit a 5 gation of resident abuse to sonnel Registry for 1 of 2 Resident #4). The findings admitted into the facility on on minimum data set 13 indicated Resident #3 as severely impaired. By working report signed on worker revealed an allegation fat read in part Resident #3 is handling him roughly and and. He also stated that the aide lothing. Unable to recall date if the person he was alleging." Inger (UM) #2 investigation ion signed on 3/6/13 indicated itigation she talked to Resident int #3 could not give an in of the alleged person, nor ime of day the incident stigation concluded when lestioned by UM #2 if any one in or hit him? He replied no. ional investigation material for e that UM #2 signed the	F	225	F 225 1. Investigation for resident #3 has been reviewed is completed thorouge day follow up report resident #4 is complete and submitted to the Health Care personne registry. 2. A review of investigation including policies and procedures that prohomistreatment, neglect abuse and misappropriation of resident property will conducted to ensure other residents have affected. A review of reportable investigation will be conducted to ensure timely reporting in place.	d and ghly. 5 for eted ations L be no been ions	

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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE C	(X3) DATE SURVEY				
PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG		COMP	ELEU	
							;	
	345434			B. WNG				
	ROVIDER OR SUPPLIER LIVING CENTER							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 225	In an interview on 3/ acknowledged the in 3/6/13 that read in para staff member was initial conversation, I accurate description also could not recall occurred. During the Resident #3 stated in #2) was talking about been rough with him was her investigation. In an interview on 3/ administrator (accondursing (DON) state coordinator. He indicated the investigation. 2. Resident #4 was 11/22/11. The quart completed on 12/28 cognitive status was 11/22/11. The quart completed on 12/28 cognitive status was 11/22/11 that report indicated that to her on the teleph informed the relative with her and tried to	19/13 at 3:40 pm, UM #2 vestigation report signed on art "Resident #3 alleged that rough with him during the Resident #3 could not give an of the person. Resident #3 the time of day the incident follow up conversation as did not know what I (UM at, when asked if anyone had or had hit him, he replied no" of the alleged allegation. 20/13 at 9:48 am, the appanied by the director of d that he was the abuse cated_that he expected UM	F	225	3. In-service education will be conducted by the Administrator and or designee to leadership staff to ensure investigation expectations and policies and procedures on investigating and reporting is clear and compliance is achieved. Education will be provided to staff by the Administrator and or designee to staff to ensure the policy and procedure that prohibit mistreatment, neglect, abuse and misappropriation of resident property to ensure compliance with this requirement.	g		

A Charles DA Coloring Colorables (Managinal Charles Shipping) and the second coloring field and the

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
: PLANOF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILD	ing			
		345434	B, WING			1	C
NAME OF DE	OARTO OR CURRUES			T		1 03/	20/2013
NAME OF PA	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 321 EAST CARVER STREET			
CARVER	LIVING CENTER						
				DC	JRHAM, NC 27704		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETION
PREFIX TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREF	1	CROSS-REFERENCED TO THE APPROPRI		DATE
				1.	DEFICIENCY)		
F 225	Continued From pa	age 3	F	225]
	UM #2's statement	t indicated upon her entry into		1			
	the room Resident	#4 reported to UM #2 that			4. On-going monitoring of		
		stants tried to force her to go to		1	1		
-		that she fought the nursing			investigation and reportin	g	
	assistants back be	cause they were fighting her.			procedures will be)
					conducted for 90 days to		
		estigation revealed no 5 day					}
	report submitted to	the HCPR.			ensure compliance with		
	la an intensions an	2/20/12 at 0:49 am the			this requirement. Finding	ţs	
		3/20/13 at 9:48 am, the opening the source of the state of the DON) stated		ļ	will be reported to the		
		day report to have been			Quality Assurance		
	submitted to the st	•		ļ	•		
	Submitted to bio of	www.dgunoy.		į	committee for review.		1
J	In an interview on	3/20/12 at 4:35 pm, the social			Policy and procedure that	£	
4		hat she faxed the 5 day report			prohibit mistreatment,		
	to the state agenc	y within the allotted time					
	requirement.			ļ	neglect, abuse and		
ĺ				1	misappropriation of		
		3/21/12 at 2:10 pm, the HCPR		1	resident property will be		
	i .	at there was no record that a 5		1	• • • •	_	
1	day report was fax				reviewed to ensure meet	5	
F 226	1 ' '		F	226	this requirement.		
SS=D	ABUSE/NEGLEC	I, ETC POLICIES					ı
	The facility must d	levelop and implement written					4/47/40
,		dures that prohibit		į			4/17/13
	, ,	lect, and abuse of residents					1
		ion of resident property.					
	This REQUIREME	ENT is not met as evidenced					
	by:						
		review and staff interviews, the					
		plement their policy for	ļ				
		report of an allegation of		İ			
	abuse to the Heal	th Care Personnel Registry for					
1 .	l						.!

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE SURVEY		
PLANOF			A. BUILD	ING_		COM	PLETED	
					·		c	
		345434	B, WING			03	/20/2013	
NAME OF PR	OVIDER OR SUPPLIER			en	REET ADDRESS, CITY, STATE, ZIP CODE			
		•			321 EAST CARVER STREET		į	
CARVER I	LIVING CENTER							
			····	<u></u>	OURHAM, NC 27704			
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD					(X6)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE	
IAG	TREADER TOTAL OIL	COOLECTIVE THIS IN CIRCUITARY	1/1/	,	DEFICIENCY)	NIE		
							İ	
F 226	Continued From page	9.4	F	226			1	
	1 of 2 sampled reside	ents (Resident #4) and failed			F 226			
	to implement their po	licy for thoroughly			, 220			
	investigating an alleg	ation of abuse for 1 of 2			d to constitute for a state	L		
	sampled residents (R	esident #3). The findings			1. Investigation for residen	(S		
	included: A review of the facility's policy for reporting				#3 has been reviewed ar	ıd		
					is completed thoroughly	. 5		
		y's policy for reporting se dated January 2009 read	ļ		day follow up report for			
		ort must be sent to Health			resident #4 is completed	l		
		lon, within five [6] working			1	i		
		acility becomes aware of the			and submitted to the			
	alleged incident."	domy bootings and our inc			Health Care personnel		1	
	anogou monoria				· ·		1	
	1. Resident #4 was re	eadmitted into the facility on			registry.			
		rly minimum data set			2. A review of investigation	IS		ļ
•	completed on 12/28/	12 indicated Resident #4			including policies and			
	cognitive status was:	moderately impaired.			procedures procedure ti	aat		
					i i	ldt		
	A review of the 24 ho	our initial report submitted to			prohibit mistreatment,			
	the healthcare person	nnel registry (HCPR) by the			neglect, abuse and			
Ì	social worker on 12/2	21/12 revealed an allegation			1			ŀ
	of resident abuse. Ur	nit Manager (UM) #2			misappropriation of			ŀ
	investigation stateme	ent dated 12/21/12 that was			resident property will be	2		1
	attached to the 24 ho	our report dated 12/21/12						1
		ent #4 relative reported over	ļ		conducted to ensure no			
		#2, that Resident #4 had			other residents have be	en		1
	1	that the aides were rough	1		affected. A review of			
<u>[</u>		force her to put clothes on.			İ			
{		:#4 fought the aides back.			reportable investigation	ı\$		
		idicated upon her entry into			will be conducted to			Ì
1	1	4 reported to UM #2 that			1			
		ints tried to force her to go to			ensure timely reporting	IS		}
1		at she fought the nursing			in place.			1
l .		use they were fighting her.						1
		man may make makening home						
	A review of the inves	tigation revealed no 5 day					į.	1
1	report submitted to the		1]
	porto-administration to							

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		& WEDICAID SERVICES	· · · · · ·). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;			CONSTRUCTION		SURVEY
TOWN OF	OJINEWHOR	WEITH WATION NOBEL	A. BUILDING				
		345434	B. WING		•		C
	NAME OF THE PERSON OF THE PERS					03/	20/2013
NAME OF PR	OVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
CARVER L	IVING CENTER			1	21 EAST CARVER STREET		
~~~~	···			D	URHAM, NC 27704		
(X4) ID		STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG	· · · · · · · · · · · · · · · · · · ·	OR LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		DATE
					DEFICIENCY)		
F 226	Continued From pa	age 5	F	226			
İ	In an interview on	3/20/13 at 9:48 am, the					1
	administrator (acco	ompanied by the DON) stated					
		day report to have been			3. In-service education will b	е	
		late agency per the facility			conducted by the		
abuse policy.					Administrator and or		
		3/20/12 at 4:35 pm, the social			designee to leadership		
		hat she faxed the 5 day report			staff to ensure		
		y within the allotted time			investigation expectations		
	•	SW indicated no specific date				>	
	that the report was	s raxeu.			and policies and		
	In an interview on	3/21/12 at 2:10 pm, the HCPR	1		procedures on		
		at there was no record that a 5			investigating and reporting	ıg	
	day report was fax	red by the facility.			is clear and compliance is		
					1		}
		cility's policy for investigating			achieved. Education will-		
	•	buse dated May 2010 read in			be provided to staff by th	e	
		of abuse must be investigated ew person/persons submitting			Administrator and or		
		witnesses (also potential			designee to staff to ensur	re	
		n written statements and			į		
		mplainant, Interview all other			the policy and procedure		
		appropriate (one employee,			that prohibit		
		, all shifts, as dictated per			mistreatment, neglect,		
	situation), Interview	w room mate as appropriate."	• [		1		
					abuse and		
		s admitted into the facility on			misappropriation of		
		sion minimum data set			resident property to		
		1/13 Indicated Resident #3			ensure compliance with		
	cognitive status w	as severely impaired.			,		
:	A review of the 5	day working report signed on			this requirement.		
		al worker revealed an allegation					
		that read in part "Resident #3					
		e is handling him roughly and					
		bed. He also stated that the aide					
		clothing. Unable to recall date					
	,	• • • • • • • • • • • • • • • • • • • •					1

家的自由人员的支撑,这个整个全个企业,是是一个企业,是是一个企业,但是一个企业的企业,但是一个企业的企业,但是一个企业的企业,但是一个企业的企业。

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OTATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION  A BUILDING			(X3) DATE SURVEY COMPLETED		
		345434	B. WING				C 03/20/2013	
•	NAME OF PROVIDER OR SUPPLIER  CARVER LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  321 EAST CARVER STREET  DURHAM, NC 27704				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 226	or the description of the A review of unit many report of the allegation as part of the investig #3, and that Resident accurate description could he recall the tin occurred. The investigned had been rough with There was no addition review from the date investigation as compliance.	the person he was alleging."  ger (UM) #2 investigation on signed on 3/6/13 indicated quation she talked to Resident of #3 could not give an of the alleged person, nor one of day the incident gation concluded when stioned by UM #2 if any one or hit him? He replied no. onal investigation material for that UM #2 signed the	F	226	4. On-going monitoring of investigation and repor procedures will be conducted for 90 days the ensure compliance with this requirement. Finding will be reported to the Quality Assurance committee for review. Policy and procedure the prohibit mistreatment,	ting o ngs		
F 323	3/6/13 that read in para staff member was rinitial conversation, Faccurate description also could not recall to occurred. During the Resident #3 stated he #2) was talking about been rough with him was her investigation.  In an interview on 3/2 administrator (accommurating (DON) stated coordinator. He indic #2's investigation to be residents, staff member and any education/in to the staff since the investigation.	out "Resident #3 alleged that ough with him during the desident #3 could not give an of the person. Resident #3 the time of day the incident follow up conversation edid not know what I (UM to the most of the alleged allegation.  20/13 at 9:48 am, the panied by the director of that he was the abuse ated that he expected UM mave included other pers that were interviewed, -services that was part of the	F	323	neglect, abuse and misappropriation of resident property will b reviewed to ensure me this requirement.	e	4/17/13	

DE PROCESSOR DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DEL COSTA DE LA COSTA DEL COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DEL COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DEL COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DEL COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DEL COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DE LA COSTA DEL COSTA DE LA COSTA DEL COSTA DEL COSTA DEL COSTA DEL COSTA DE LA COSTA DEL COSTA DEL COSTA DEL COSTA DEL COSTA DEL COSTA DEL COSTA DEL COSTA DEL COSTA DEL COS

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:			ONSTRUCTION		TE SURVEY
,, = +.			A. BUILD	ING	· · · · · · · · · · · · · · · · · · ·		
		345434	B. WNG				C 03/20/2013
	ROVIDER OR SUPPLIER			321	ET ADDRESS, CITY, STATE, ZIP CODE EAST CARVER STREET RHAM, NC 27704	<u> </u>	13120/2013
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(XS) COMPLETION DATE
F 323 SS=D	HAZARDS/SUPER The facility must energy environment remains as is possible; and		F	323	F 323  1. Resident #2 is receivi assistance by two stamembers and the details of any falls are being evaluated to	ff	
	by: Based on resident record review, the providing care and so that effective interpretation of three residents (Findings included:	NT is not met as evidenced  and staff interviews and facility failed to have 2 staff evaluate the details of the fall eventions could be put in rther falls from the bed in one (resident #1) reviewed.  dmitted to the facility on			ensure appropriate interventions are in place to prevent furt incidents.  2. A comprehensive review of residents a risk for falls to be conducted by 4/12/2 to ensure appropriate	ot :	
	A review of resider Set (MDS) dated 2 cognately intact who and fall with no injuthat resident #1 resident #1	nt #1's quarterly Minimum Data //25/13 indicated that he was th no behaviors and he had ury. This MDS also indicated quired total assistance with 2 ty, transfers, toileting and		* Tetropromonianomologico/cicio-cicio-cicio-cicio	interventions and assistance is in place prevent falls. Appropriate and comprehensive plan care will be updated prevent further falls	e to; i of i to	
	11/27/12 indicated 2 staff for bed mob bathing. There wa	nt #1's care plan initiated the need for total assistance of illity, transfers, tolleting and is a care plan for falls dated ited 1/28/13 to Include 2 staff	7 7777 77 77 77 77 77 77 77 77 77 77 77				

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	IDEADEROATION MUNDED.			CONSTRUCTION	(X3) DATE SURVEY			
1			A. BUILD	ING		1 00			
		345434	B. WING		Transfer day, a harmonia	03	C 3/20/2013		
	NAME OF PROVIDER OR SUPPLIER  CARVER LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  321 EAST CARVER STREET  DURHAM, NC 27704				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE.	(X5) COMPLETION DATE		
F 323	A review of the incide indicated that one aid #1's activities of daily when he experienced Interventions included person assist during report did not indicate complaints of pain an injury on assessment was a witness preser not interviewed at the A review of the physical #125/13 indicated that left shoulder and left swelling or deformity shoulder. X-Rays we negative for evidence A review of the nursin 1/29/13 did not reveat to the fall except for shoulder and left hip.  On 3/20/13 at 10:20 observed sitting up in muscle spasm to his took medication for reconstruction of the construction of the fall except for shoulder and left hip.	ant report dated 1/25/13 le was performing resident living (ADL's) in the bed la muscle spasm. d floor mats at bedside and 2 his ADL care. The incident e that resident #1 had any d there was no apparent . The report indicated there at and that the resident was e time of the fall.  cian's progress note dated t resident #1 complained of hip pain. There was no of the left hip or left re ordered and both were e of fracture.  In any noted concerns related some voiced pain to his left  AM, resident #1 was a bed. He was experiencing a left hand. He stated he just elief.	F	323	<ol> <li>Education to staff to be completed by Director of Nursing and or designee to ensure residents in need of assist of 2 or more are receiving appropriate assistance; and education on preventing residents at risk for falls not being left unattended to assure compliance with this requirement.</li> <li>On-going monitoring of fall prevention interventions to be completed for 90 days to ensure compliance with this requirement. Findings will be reported to the QA committee for review.</li> </ol>		4/17/13		

STATEMENT OF DEFICIENCIES  PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	IDEKIDERATION MUNOCO		ONSTRUCTION	(X3) DATE SURVEY	
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	NAME OF PROVIDER OR SUPPLIER  CARVER LIVING-CENTER			321	TADDRESS, CITY, STATE, ZIP CODE EAST CARVER STREET RHAM, NC 27704	1 03/	20/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTIO TAG CROSS-REFERENCED TO THE DEFICIENCY)			(X5) COMPLETION DATE
F 323	and resident #1 was for his ADL's. The nu stated she did not no the incident report not #1 was not questione #1 stated that at the that the resident was transfers only.  On 3/20/13 at 11:50 #1 stated she was the on 1/25/13 at the time completed his bath a stated she left reside bed to go to the door her get resident #1 or resident #1 had a sp. #1 could not recall it his side rail up when stated she thought re assist for transfers or was to follow the care know how to care for On 3/20/13 at 11:55 that the aides follow to know how to care nurse stated she upo 1/28/13 to include the for his ADL's but did care planned for 2 st care plan.  On 3/20/13 at 1:20 PNA #1 had given him edge of the bed whe him up out of the bed	changed to a 2 person assist ursing unit manager #1 tice the witness indicated on or did she notice that resident ad. The nursing unit manager time of the fall, she thought a 2 person assist for  AM, nursing assistant (NA) e NA assisting resident #1 e of his fall. She stated she and ADL care alone. NA #1 and #1 in the middle of the way to get someone to help ut of the bed. NA #1 stated assm and fell off the bed or put she left the bedside. NA #1 esident #1 was a 2 person and. NA #1 stated the staff e plan in the computer to	F	323			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE	SURVEY
<u>'</u>			A BOILD	ING_			c
.,		345434	B. WING			03/20/2013	
	OVIDER OR SUPPLIER			. 3	REET ADDRESS, CITY, STATE, ZIP CODE 21 EAST CARVER STREET DURHAM, NC 27704	****	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH COF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	the floor. He stated the position and his side stated he was not injuted. On 3/20/13 at 1:30 PI (DON) stated she was the room doing ADL concident. She stated smorning meeting that and slid off the other spasm. She indicated witnessed the fall and left resident #1 on the went to the doorway the con-3/20/13-2:20 PM.	ed he fell from the bed onto se bed was not in the low rall was not engaged. He stred  M, the director of nursing s aware that NA #1 was in care at the time of the she was told during the resident #1 was on his side side of the bed due to a I she thought NA #1 I was not aware that NA #1 Is bed unattended while she	F	323			
	resident #1 lying on the nurse and resident he was moved. She says a series always get assistance toilet him because he that he would sometime could not control his as she followed the care know how to care for On 3/20/13 at 3:15 Pattempted to contact #1 at the time of the sunavailable for intervexpectation would be resident #1's ADL care	the floor. She stated she got at #1 was assessed before stated she worked with all occasions and would be when she would bathe or was so stiff in his joints and mes have spasms where he movements. NA #2 stated a plan in the computer to her assigned resident's.  M, the DON stated she the nurse assigned resident fall on 1/25/13 but she was lew. The DON stated her of or 2 staff present during re and transfers. The DON ould not be left unattended	A CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA CANADA				

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	ROVIDER OR SUPPLIER		321 E	FADDRESS, CITY, STATE, ZIP CODE EAST CARVER STREET RHAM, NC 27704	<u>-</u>		
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F 323	On 3/25/13 at 10:14 day of the fall, NA # medication cart and floor. Upon entering rolled resident #1 o experienced a spass the floor between the stated resident #1 no complaints of particular particular and complaints of particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particular and particula	age 11 4 AM, nurse #2 stated on the #2 approached her at her if stated resident #1 was on go the room, NA #1 stated she ever to wash him and he sm. He rolled off the bed onto the wall and bed. Nurse #2 was lying on his side and had ain. He wanted to be gotten up de to smoke. Nurse #2 stated the had a spasm and rolled	F 323				